VALUING STAFF, VALUING PATIENTS

THE REPORT ON
THE PSYCHOSOCIAL CARE AND MENTAL HEALTH PROGRAMME

FOREWORD BY THE CHAIRMAN AND PATRON OF THE FPHC OF PRE-HOSPITAL CARE

The psychosocial and mental health of health service workers has never been higher on the agenda of healthcare employers. There is a genuine desire to properly look after those on the frontline of emergency patient care. Not only is this a moral and, to some extent, statutory imperative but it is also vital to ensure that a stable and resilient workforce is available to manage regular emergencies and extraordinary situations. We recognise that the pre-hospital environment is an even less predictable working environment than in-hospital and that difficult situations are commonplace. There is also considerable evidence to suggest that psychosocial and mental health problems are relatively common in our workforce. We commissioned this programme to address these issues. We wanted to establish the scale of existing problems, what background information we need to understand them, what prevention and interventions might help and what we can practically do at operational level to make a difference.

Professor Richard Williams is very well qualified to lead our programme and has successfully led many initiatives for the emergency community. Despite delays caused by the ongoing pandemic the programme has steadily advanced, and this report is an important first output. We hope it will be an effective guide to improve working conditions for our membership and the wider pre-hospital community.

The report has been carefully divided into sections that can be viewed as a whole or in isolation. The background of how our workplace can affect our mental health is covered in detail along with recent reports on the magnitude of the problem. The effect and influence of the recent pandemic and its effect on healthcare workers cannot be underestimated and is discussed here. One of the most important concepts is also introduced in this section. There are ways to improve our working environment but there will always be a risk of conflict, distress and hostility at the scenes of trauma and critical illness. We cannot rely on modification of these stressors to improve working conditions because they are mostly outside our control. Importantly, what is also identified are the 'secondary stressors' which are so important in generating or amplifying the problems that we commonly encounter. Many of these are definitely open to influence. Understanding and addressing these problems are likely to be the mark of an effective pre-hospital organisation and, of course, many are already tackling them effectively.

This programme had most access to pre-hospital emergency medicine trainees who may report a specific set of circumstances. However, many of the issues they describe are common to other areas of pre-hospital practice and the recommendation of this report are based on a wide evidence base. The practical peer support training, which is recommended, has already been piloted in the UK and provides the opportunity to provide the majority of necessary support within organisations. It has real potential to deliver benefit and prevent escalation of problems with only moderate organisational investment.

We look forward to seeing the benefits of implementing these recommendations in UK pre-hospital care in the years to come. We are confident that, if acted upon, there will be a healthier and more cohesive workforce better equipped to cope with whatever our workplace throws at us. We are also delighted that this programme has been supported by the Royal Foundation which has delivered so much to mental health projects for the emergency community.

Professor David Lockey
Gibson Professor and Immediate Past Chair, Faculty of Pre-hospital Care, Royal College of Surgeons of Edinburgh

Professor Sir Keith Porter
Patron, Faculty of Pre-hospital Care, Royal College of Surgeons of Edinburgh

PROGRAMME DIRECTOR'S PREFACE

It has been a privilege and a pleasure to lead the team of people who have contributed so much to the report and to the work that lies behind it.

The matters reported on here came to the fore in 2017-18 when the Faculty of Pre-Hospital Care in the Royal College of Surgeons on Edinburgh (FPHC) expressed its concern about the pressures on trainees in pre-hospital emergency medicine (PHEM) and decided to promote a programme to bring forward guidance. This decision by the FPHC was visionary and this report is one of the products of the work done by the Programme Team. I was very pleased to accept the FPHC's invitation to lead it. I take this opportunity to thank the FPHC and all the people who have worked on this programme. They have brought to bear enormous dedication, experience, and expertise and enthusiasm for working collaboratively. Importantly, they have been remarkably open about their own experiences and that has helped us to move forward in no small degree. They made it possible for this programme to contribute to assisting the practitioners who work in extraordinary circumstances to do so much for people who face such challenging injuries and illnesses. The Programme Team has benefitted from the experience of PHEM practitioners from all levels of experience, at different points in their careers and from a range of different clinical backgrounds.

I have been raising the matter of the importance of caring well for and supporting the staff of the NHS over a long time. My work in this domain in relation to PHEM started back in 2008 when I was nominated by the President of the Royal College of Psychiatrists to attend meetings, convened by Sir Peter Simpson, past President of the Royal College of Anaesthetists, to endeavour to establish PHEM as a subspecialty with the General Medical Council. That group of people, and the Colleges they represent, became the first Intercollegiate Board for Training in Pre-Hospital Emergency Medicine (IBTPHEM) and I have continued to work with it since then. The matters that are the subjects of this report have also been the concern of IBTPHEM. Successively, its officers have welcomed our work and supported us by enabling us to test our emerging ideas with trainees in the new subspecialty on its courses.

Early on, the Programme Team decided to take an evidence-informed and values-based approach. We wanted to represent science alongside practice in our recommendations. We determined to create proposals that are practical and capable of implementation in PHEM settings that are likely to meet the needs of the FPHC's members. Thus, the recommendations in this report set out a range of proposals for supporting the health, wellbeing, and psychosocial care of PHEM practitioners. We say less about the mental health disorders that some people might develop believing that providing services for them is a matter for specialist mental health services. Rather, we focus most on the nature of the care that employers and the professions should enable practitioners to receive every day.

As the programme progressed, we have described the outputs proposed in various settings including FPHC and Trauma Care conferences and webinars and at the PHEM national induction training. We took the opportunity to trial implementation of Peer Support training, for example, during the pandemic by translating a two-day face-to-face course into an online Zoom programme delivered in a single day. In these ways, we have worked closely with PHEM practitioners and intensivists.

The pandemic has changed the culture in which healthcarers work, increased sensitivity to the needs of staff and the importance of the quality of care available for staff before emergencies begin and levels of secondary stressors. Inevitably, our progress was slowed by COVID-19. However, the experiences of staff working through the pandemic have helped to test and inform the recommendations.

Professor Richard Williams
Director of the Psychosocial and Mental Health Programme for the Faculty of Pre-hospital Care in the Royal College of Surgeons of Edinburgh

THE COMMISSIONER

This report, and the programme on which it is based was commissioned by Professor David Lockey on behalf of the FPHC of Pre-Hospital Care in the Royal College of Surgeons of Edinburgh

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Mr Terry Simpson, Head of Mental Health Service, East Midlands Ambulance Service NHS Trust.

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We acknowledge the support given by The Royal Foundation of the Duke and Duchess of Cambridge.

USE OF THER MATERIAL IN THIS REPORT

CONTENTS

EXECUTIVE SUMMARY

An Overview of This Report

In Autumn 2018, the Faculty of Pre-Hospital Care of the Royal College of Surgeons of Edinburgh (FPHC), established a programme to develop guidance on psychosocial care for practitioners of pre-hospital care. This report is one product of that programme undertaken by a team of senior and trainee practitioners of pre-hospital care and other specialties led by Professor Richard Williams. It includes an overview of the origins and impacts of the stress that affects trainees and staff working in pre-hospital settings. It reports on surveys and reports that shows that the human cost of distress and mental health problems experienced by staff employed in healthcare settings is huge for many people, and it extends to their colleagues and families. People who work in pre-hospital care are susceptible to these impacts.

The Programme Team and its leaders conducted a huge amount of fieldwork by visiting practitioners and services and attending conferences. They have also participated in the Phase 1 and Phase 2 Courses for trainees in pre-hospital emergency medicine. They are aware that the PHEMTA Surveys indicate that there are many positive themes in the experiences of doctors training in pre-hospital care. Usually, they enjoy their placements and feel well resourced, well supervised, and well supported at work. They also feel positive about the quality of care they deliver and recognise the positive impact this has on their patients and families. Nonetheless, those surveys also identify persisting problems that adversely affect trainees' experiences. Many of those matters are what this report shows to be secondary stressors that could be reduced in a pliable employment system.

The work of the Programme Team has been punctuated by the pandemic caused by the SARS-CoV-2 virus. Although the team kept going throughout that emergency, many members have been, rightly and reasonably, preoccupied with the clinical realities of the pandemic. However, we have also learned a great deal from the pandemic about psychosocial and mental health matters as they pertain to healthcare staff and the application of approaches to sustaining staff during the pandemic that had appeared of similar importance to the Programme Team before the pandemic and has provided valuable learning that can be applied equally during non-pandemic times

There is an increasing body of literature showing that the impact of the COVID-19 pandemic has and is adding hugely to the pressure felt by staff who work in healthcare settings. It has created a major focus on their experiences and the many ways in which staff have been affected by extraordinary circumstances. In 2021 and into 2022, large numbers of staff reported enormous fatigue. Some staff members have clearly been distressed. It is too early to know how long those experiences will last and how many staff may develop mental health disorders as a result of what they have been through. In that regard, we recognise past learning that the impacts of major incidents may not manifest until some years have passed. We require longitudinal research of high-quality design to discover the answers to these questions.

In the meanwhile, we have been forcibly struck by the applicability of the material contained in this report, much of which reflects work performed prior to the pandemic, to supporting and caring for staff of the NHS during the pandemic. The Programme Director has been an adviser to NHS England and NHS Improvement (NHSEI) throughout. The pandemic has allowed the director and project manager to test components of psychosocial care with practitioners and to bring forward and begin evaluation of one particular intervention that is increasingly popular - Peer Support. They have tested it with teams in pre-hospital care and intensive care units and created a one-day, team-based, online training course in the modality.

A Summary of The Recommendations

This summary of the recommendations introduces concepts in advance of more detailed coverage in Part 4 of this report. A glossary of key terms is found on pages 65 and 66 in Part 5.

There are 12 primary recommendations in this report. They are summarised below. The full text of the recommendations can be found at pages 52 to 56.

The first recommendation is an overarching set of 15 'Golden' Approaches and there are 11 more specific recommendations that are intended to assist readers, and employers to achieve effective care for staff of all disciplines in services that deliver pre-hospital care.

Some recommendations are addressed to the FPHC. The authors recognise that it does not employ staff or mandate employers. However, the FPHC commissioned this work, and it is well-placed to influence professional opinion and good practice, and influence the plans made by employers who may look to the FPHC for guidance.

Recommendation 1: The 15 Golden Approaches

There are 15 key matters that are imperatives for all organisations that put in place care for the wellbeing, psychosocial and mental health needs of their staff. They are based on a psychosocial and non-medical approach to meeting most people's needs. They are to:

- Provide clear messages about the priorities of work and care for staff within organisations
- Ensure every employee has a person or a place to which they can go for immediate support and ensure staff have space and time for reflection (an example might be a buddy system among colleagues)
- Ensure that work is based on effective teams and that team cohesion is supported by employees training together
- Develop care pathways that link the wellbeing, psychosocial and mental health aspects of the organisations' workforce plans into the clinical and governance roles in pre-hospital care
- Ensure that leaders are effective and supportive to enable people and develop team cohesion
- Intervene early with staff who are distressed – this requires strengthening the working environment, and listening rather than providing, for example, therapy or counselling
- Adopt a practical approach to early intervention based on the acronym **PIES**; that is to provide interventions in **proximity** to where people work, with **immediacy** and **expectation** of recovery and by using **simple** interventions first – there is evidence that this approach lessens the risks of staff members developing mental health disorders later
- Learn and use active listening skills
- Seek out and remedy secondary stressors
- Ensure that employees are offered opportunities for integration with their peers because social support is key
- Remember that colleagues' senses of personal efficacy and agency are important features in their recovery

- Consider Peer Support programmes because they bring staff in departments and teams together and may prevent development of more serious problems
- Be clear about who will and will not benefit from a 'medical' approach (a minority of people may develop diagnosable mental health disorders for which they require specialised medical care, but most do not)
- Support staff in the face of negative public perceptions
- Get workplace culture right: the actions and policies in this list are all critical to creating environments at work that are conducive to staff giving of their best. This means that policies and actions for supporting staff must be separate from those for staff discipline and performance management.

Recommendation 2: FPHC and the Inter-Collegiate Board for Training in Pre-hospital Medicine (IBTPHEM) should work to highlight the welfare issues likely to affect those people who work in pre-hospital environments and promote positive moral architecture in their own and employing organisations

This recommendation relates to an important contribution that the FPHC and IBTPHEM could make to improve care for practitioners of pre-hospital care. It is that of adopting an active stance of continuing to advocate for improvements in the care of, and support for trainees and permanent staff in all pre-hospital disciplines. The Programme Team recognises that the FPHC is not in a position to directly improve that support and care across the system because staff are employees of healthcare bodies that have the primary responsibilities for the welfare, wellbeing, and mental health of their staff. Nonetheless these organisations can act as exemplars and advocates of good practice in the psychosocial field.

Recommendation 3: FPHC should encourage employers of PHEM practitioners and trainees to take steps to reduce primary and secondary stressors to a minimum

This recommendation concerns the recognition that it is now commonplace to separate the circumstances and events that are stressful into primary and secondary stressors. They are common to all organisations. Primary stressors tend to receive the greatest attention in practice and research. However, experience and emerging research demonstrate that secondary stressors are not only potent but often amenable to improvement. The PHEMTA surveys show that many of the matters that impact trainees are secondary stressors and that they are tractable, and most are neither implicit in events nor immutable.

Recommendation 4: FPHC should recognise that cohesion and leadership are vital to good care of staff

There is copious research to support conclusions that working in well-led, coherent groups is a very important aspect of getting right the culture of health and social care organisations and is likely to offer strong protection for the wellbeing of staff.

Recommendation 5: FPHC should encourage pre-hospital organisations to adopt a non-medicalised approach to improving care and support for staff. This should be balanced with opportunities for signposting staff in greater need to more specialised health services

The problems that affect staff of pre-hospital care services are often not indications that staff have developed or are developing mental disorders. This reveals a problem with terminology and the huge potential for misunderstandings about the meaning of terms such as welfare, wellbeing, psychosocial care, and mental healthcare. This report recommends that the main approaches to caring for staff should be non-medical and that they should be made readily available. However, it should be recognised that a small proportion of staff may develop mental health problems of more serious natures that may require specialist assessment and treatment. There should be no complacency about this possibility and the non-medical facilities that offer psychosocial care should be capable of signposting those in need to more specialised services as early as possible and, possibly, to and through occupational health services.

Recommendation 6: FPHC should encourage pre-hospital organisations to adopt a stepped approach to caring for staff

This report proposes that the FPHC adopts a stepped approach to the care of staff and their trainees as policy, that is capable of being embedded into other organisations that employ staff to work in pre-hospital care. This consists of: a wellbeing agenda for all; psychosocial care for those people who are struggling; and agreed pathways to effective specialist care for those people who need specialist mental healthcare.

Recommendation 7: FPHC should appoint a lead to ensure that progress is made on delivering the wellbeing, psychosocial and mental health agendas among FPHC members

The Programme Team recommends that the FPHC should appoint a lead to carry forward the work of the programme into the future by disseminating the learning gained during the programme's work.

Recommendation 8: FPHC and the IBTPHEM should urge the employing and regulatory organisations to review how trainees in pre-hospital emergency medicine are selected and allocated to placements

The House of Commons report on Workforce Burnout and Resilience in the NHS and Social Care was published on 8 June 2021. Its conclusion contains the statement: 'The emergency that workforce burnout has become will not be solved without a total overhaul of the way the NHS does workforce planning.' It appears to the Programme Team that this recommendation frames an important opportunity to revisit and revise aspects of the way in which trainee posts in pre-hospital medicine are allocated and advertised with a view to improving certain problems that trainees drew to our attention. We recommend that steps be taken to improve gender equality and to reduce how training placements are allocated in order to reduce trainees working at great distances from their homes and families. We recognise that these are challenging matters but recommend that active steps be set in course.

Recommendation 9: FPHC should encourage pre-hospital care organisations to promote knowledge of the scale and impact of the exposure of their staff to distress arising from their work

Healthcare staff who work in pre-hospital environments are required to do demanding and skilful work in hazardous environments. They are exposed to extraordinary events and may witness suffering, distress and death, with unusually high frequency. Inevitably, some of the impacts are stressful by virtue of the enormity of other people's suffering and their injuries.

Recommendation 10: FPHC should encourage pre-hospital care organisations to promote knowledge about the emotional labour ordinarily carried out by their staff

A substantial amount of emotional labour is implicitly required by pre-hospital healthcare professionals who regularly support patients and their families through suffering and distressing events.

Recommendation 11: FPHC should encourage pre-hospital care organisations to promote knowledge of the evidence showing that responders are likely to be at risk of the psychosocial and mental health consequences of their involvement in significant emergencies and major incidents

The distress that staff experience and the dysfunction and disorders they risk are similar to the conditions that affect survivors of significant and major incidents. Yet, staff may feel stigmatised by recognising or showing the emotions they experience and any problems they develop. Staff who experience distress that persists for more than two weeks after a significant event should receive assessments of their needs.

Recommendation 12: FPHC should encourage pre-hospital care organisations to promote knowledge of the evidence showing that employees gain psychosocial benefits from knowing that their employer has a comprehensive strategy in place to support their wellbeing, psychosocial needs and mental health and that employees who are well supported tend to make fewer mistakes

Pre-hospital care organisations should develop a strategy for supporting the wellbeing, psychosocial care, and mental health of their staff. Staff should be aware of the existence of this strategy and should have access to it. The Faculty of Pre-Hospital Care is in a strong position to promote dissemination of the knowledge and skills required to deliver effective wellbeing, psychosocial care and mental healthcare through organisations that deliver pre-hospital care services.

INTRODUCTION

The Origins

This document reports the work of a team of practitioners of Pre-Hospital Emergency Medicine (PHEM) from a range of disciplines and other trauma-care practitioners who agreed to work under the leadership of Professor Richard Williams and the Project Manager, Ms Verity Kemp. They were charged by the FPHC of Pre-Hospital Care (FPHC) in the Royal College of Surgeons of Edinburgh to make recommendations to improve the psychosocial and mental health care of PHEM practitioners.

The intention of the programme is to provide support for practitioners of pre-hospital care, trainees, trainers, relevant professional bodies, and employers by providing guidance on improving the care and supervision of practitioners. The outputs from the programme, including this guidance, are based on reviews of the best available evidence from current clinical, scientific, managerial and policy sources.

Several other pre-hospital organisations including the Intercollegiate Board for Training in Pre-Hospital Emergency Medicine (IBTPHEM), the British Association for Immediate Care (BASICS) and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) also expressed interest in the aims and outputs of this programme.

The programme commenced in October 2018. At the beginning, it was anticipated that the programme would report in early 2021. But inevitably, progress has been disrupted by the COVID-19 pandemic. However, the impact of the pandemic on staff in health and social care has emphasised the importance of identifying members of healthcare staff who are upset, struggling or distressed and before they become clinically unwell. The authors of this report are pleased to report that so much was achieved despite the impacts of the pandemic. We repeat our thanks to the Programme Team for its work.

The Purpose

The purpose of this report is to indicate how the psychosocial care and mental healthcare of practitioners of pre-hospital care be improved. The core themes are:

- Defining the nature and management of distress.
- Meeting the psychosocial and mental health needs of practitioners of pre-hospital care including trainees.

The Contents

In this introduction, we outline the contents of this report including:

1 The nature of the impacts of work on the mental health of staff

2 A strategic framework for planning and delivering services

3 Terminology

4 A practical approach to caring for staff on pre-hospital services.

The Nature of The Impacts of Work on the Mental Health of Staff

This programme has focused on the people who work in pre-hospital environments. The basis of the actions undertaken by the Programme Team has been to:

- Survey informally the nature of work in delivering pre-hospital care
- Undertake a systematic review of the literature (consequent on the pandemic, the full findings will not be available until summer 2022)
- Consider its advice to FPHC based on these sources.

At the core of the Programme Team's work lies the importance of recognising that staff give of themselves enormously in the course of the work they do and that these gifts are not the subject of contracts with employers.

While many people become reasonably and appropriately distressed by what they do, most staff who become distressed are temporarily upset and recover well with the support of their families and colleagues at work. However, some members of staff may enter periods of greater or more persistent distress. Most of them are also likely to recover over time but some of them may be helped by more substantial interventions from colleagues and services. A much smaller number of people may become ill and require referral for more specialised assessment and, possibly, treatment. This report identifies that there are these three overlapping groups of people and Part One of this report summarises the approach to this matter taken by the Stevenson-Farmer Review. The Programme Team discerned that guidance is required at these three levels.

A Strategic Framework

First, the Programme Team identified the lack of a strategic framework for planning, designing, and delivering wellbeing support, psychosocial care, and mental healthcare for practitioners of pre-hospital emergency medical care. Part 1 of the report provides an overview of the impacts of work on people's mental health, particularly focusing on the Stevenson-Farmer Review, which identified three challenges to employers.

Part 2 considers work in pre-hospital emergency care and focuses on the nature of that work, the common experiences of PHEM practitioners and trainees including the importance of diversity and a description of the research commissioned as part of this review.

The matters reported there lead on to the framework for caring for the wellbeing, support and the psychosocial and mental health needs of staff in Part 3. The Model of Care on page 42 draws together the three agendas to which employers should attend in seeking to create comprehensive support services for their staff. The contents are consistent with the recommendations of the Stevenson-Farmer Review.

Terminology

The second matter on which guidance is required is that of terminology. The Programme Team found that, presently, there is a plethora of terminology which is often used inconsistently. Terms such as 'wellbeing', 'welfare', 'psychological care', 'mental health' tend to be used broadly to refer to the whole field of people's experiences and needs. The Programme Team proposes using explicit terms in a more consistent manner. Therefore, it provides a glossary of terms among the resources in Part 5 of this report. Here are some examples:

Wellbeing

The term 'wellbeing' is used in this report to refer to every member of staff's needs for sources of support to ensure that they are able to continue to develop, enjoy the stimulation of their work, and

flourish. Every member of staff, for example, requires effective leadership and to be a member of a cohesive team that is supporting and nurturing.

Psychosocial Care

From time to time, members of staff may struggle at work and/or at home. They may well recover with support by colleagues as well as their families. Some people who are struggling, including those who are distressed for longer periods, may benefit from interventions based on the principles of psychological first aid that are not medical in nature and which do not seek to pathologise their needs and methods of meeting them. This is named psychosocial care because many of the factors that cause concern lie in the social and psychological areas rather than reflecting medical needs. Social support is critical to meeting the needs of people in these circumstances. Some members of staff may find that being able to call on colleagues for Peer Support is extremely helpful. Psychosocial care is based on taking a non-pathologising approach to meeting the needs of staff who are struggling.

Mental Healthcare

Some staff may have more persistent needs and a small number may have needs that go beyond psychosocial care. The approach taken in this report recognises that some people may require skilled mental health assessments by general practitioners, occupational health teams or psychiatric services. They may need to be assessed for mental health disorders by staff of a specialist mental health service. This report says little about specialist mental healthcare but comments on where it fits into the spectrum of responses to the needs of staff and focuses on those aspects of care to which colleagues could and should contribute.

This introduction identifies the terms that are preferred in this report, but also there are many more. A glossary of the terms used in this report is on pages 65 and 66 in Part 5.

A Practical Approach

Parts 1 to 3 of this report endeavour to show how practical approaches arise from, and are linked through a series of core considerations. These parts include straightforward accounts of stress, distress and mental disorders and a survey of the impacts of emergencies and major incidents on staff. These matters are also the subjects of two Annexes in Part 6. There are no complex psychological or mental health theories in this report or the Annexes.

Readers may require advice on practical actions that they may take when they are concerned about themselves, a colleague, or colleagues. The Programme Team has included in Part 5 of this report a collection of resources; they include Dos and Don’ts and a substantial guide to online resources.

PART ONE: BACKGROUND

THE IMPACTS OF WORK ON THE MENTAL HEALTH OF PEOPLE WORKING IN ORGANISATIONS PROVIDING PRE-HOSPITAL CARE

As a rule, work, is good for our mental health, but a negative working environment can lead to physical and mental health problems. The WHO definition of mental health is 'a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community'. This is a very challenging goal to maintain consistently.

An Approach to Understanding the Experiences of Staff Who Deliver Pre-Hospital Care

In the course of its work, the Programme Team, has read a substantial number of accounts and papers. One of them identifies several steps that pre-hospital care practitioners go through as they prepare for action, respond to call-outs and recover afterwards. The team thinks that this stepwise approach is useful in terms of how staff approach each event to which they are called and its psychosocial impacts on them. They are:

Anticipation:	An inner dialogue to prepare in the face of paucity of information
Touchdown:	The first point at which the realities of the situation and patients' needs meet a practitioner's expectations
Delivering care & treatment:	Meeting patients and participating in their care and experience of intense and challenging circumstances and possibly facing patients' demise
Reflection:	Facing thoughts about success and pride in a job done well, possible failure, guilt, shame, and lasting feelings of doubt in settings that may not enable sufficient time for recovery. These experiences may be cumulative.
Healing & re-orientation:	Staff may need to recover from a wide array of feelings about their work, its implications for patients, themselves and the service.

Developed from Jonsson and Segesten, 2004[1]

Awareness of the processes through which staff go in tackling each event is helpful in understanding what might be their needs beforehand, at the time and afterwards. The literature is clear, for example, that all-too-often, staff are afforded too little time for reflection after significant events. Sometimes, staff engage in reflection on their way home at the end of shifts. This and their fatigue may raise the risk of inattention while driving.

Compassionate Care for Staff

The staff of health services are renowned for their resourcefulness under pressure. Public expectations are that staff consistently deliver effective, evidence-based care and interventions sensitively and compassionately even if the environments in which they work are not optimal. However, it is difficult for healthcare staff to continue to provide compassionate, evidence- and values-based care for their patients without the support of their employers or if there is dissonance between the quality of support and training for staff and the quality of care that they are expected to deliver. This is especially so when employers implicitly or explicitly expect staff to take more than minor risks. Delivering healthcare during

the COVID-19 pandemic has provided many practical lessons for caring effectively for healthcare staff and reducing the risks that staff face.

Generally, there is potential for healthcare practitioners, including staff of responding services, to neglect their own physical and emotional needs. More extreme effects of the exposure of staff to crises and people's suffering include burn out, compassion fatigue, and vicarious and secondary traumatisation. All staff routinely require social, peer and managerial support, training, and professional and management supervision. These are overlapping, but different, processes.

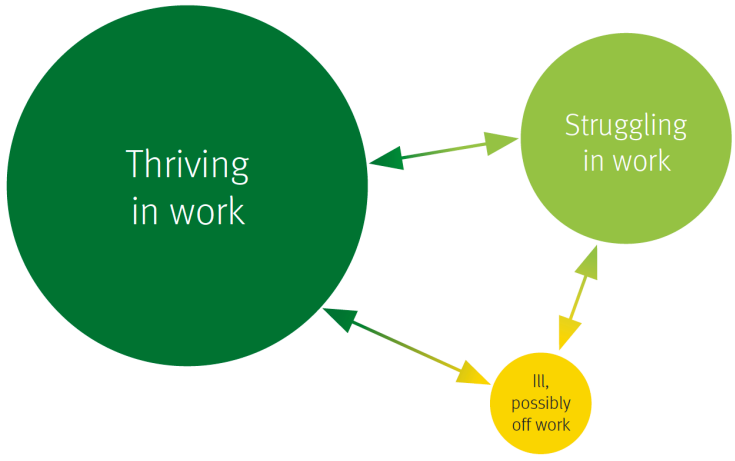
The relationships between leaders, managers and staff have been identified as predictors of both wellbeing and people's absence. Other factors include providing sufficient resources, adequate peer support, adequate information about events, tasks and situational factors, and ensuring effective professional and managerial supervision. NHS staff also talk of the importance of having satisfactory arrangements to take breaks and refreshments and of having facilities to rest before driving home after demanding shifts. These wider aspects of working environments also influence whether staff are enabled to cope well and sustain compassionate care for their patients. Again, experiences before and during the COVID-19 pandemic have powerfully illustrated these observations.

The Stevenson-Farmer Review

The Stevenson-Farmer Review of mental health and employers was published in 2017 and is relevant to all types of organisations.[2] It identifies three broad groups of staff in any organisation that are shown in Figure 1. Their report considers how employees might be better supported. Its findings are particularly relevant to staff of organisations that deliver care for other people as their main function, including those working in pre-hospital environments. The report presents three challenges to employers that are summarised in Figure 1 and listed below.
They are:

- Assisting employees to thrive at work
- Supporting staff who are struggling
- Enabling people who are ill to recover and return to work.

Figure 1: Three phases people experience in work (Stevenson and Farmer 2017) (© Crown copyright 2017: reproduced under the Open Government Licence v3.0)



Valuing Staff, Valuing Patients

The report shows that the human cost of mental health problems is huge, with poor mental health having an impact on the lives of many people and those around them both at work and home. It highlights that rates of poor mental health and suicide are higher for employees in certain work settings. It notes that the NHS is one such setting and makes recommendations to NHS England (now NHS England and NHS Improvement) to continue to foster and support good mental health in the workplace.

Separately, NHS Employers reported that:[3]

- Doctors are twice as likely to kill themselves than those working in other professions.
- Nurses are four times as likely to take their own lives than people working in any other profession in the UK.
- Female nurses are more likely to commit suicide than their male counterparts

Some highlights from the NHS Staff Survey of 2019 are detailed later in the report.[4]

In a poll conducted in 2016 by the mental health charity Mind, through its Mind Blue Light Programme, the findings were that one in four emergency service workers had considered ending their lives and 41 per cent had been prescribed medication to deal with work-related issues.[5] The online survey received responses from over 1,600 staff and volunteers from police, fire, ambulance and search and rescue services. It also showed that 92 per cent of respondents experienced stress, low mood and poor mental health.

Families

Alleviation of people's suffering can be facilitated by family members, colleagues and practitioners in the preparedness and response phases. This can also accelerate their adaptation and recovery and prevent the development of mental disorders in the medium- and longer-terms by offering social support and contributing to community development. Advice about communicating with the public about risks is available in the literature, e.g., the work of Bish et al..[6]

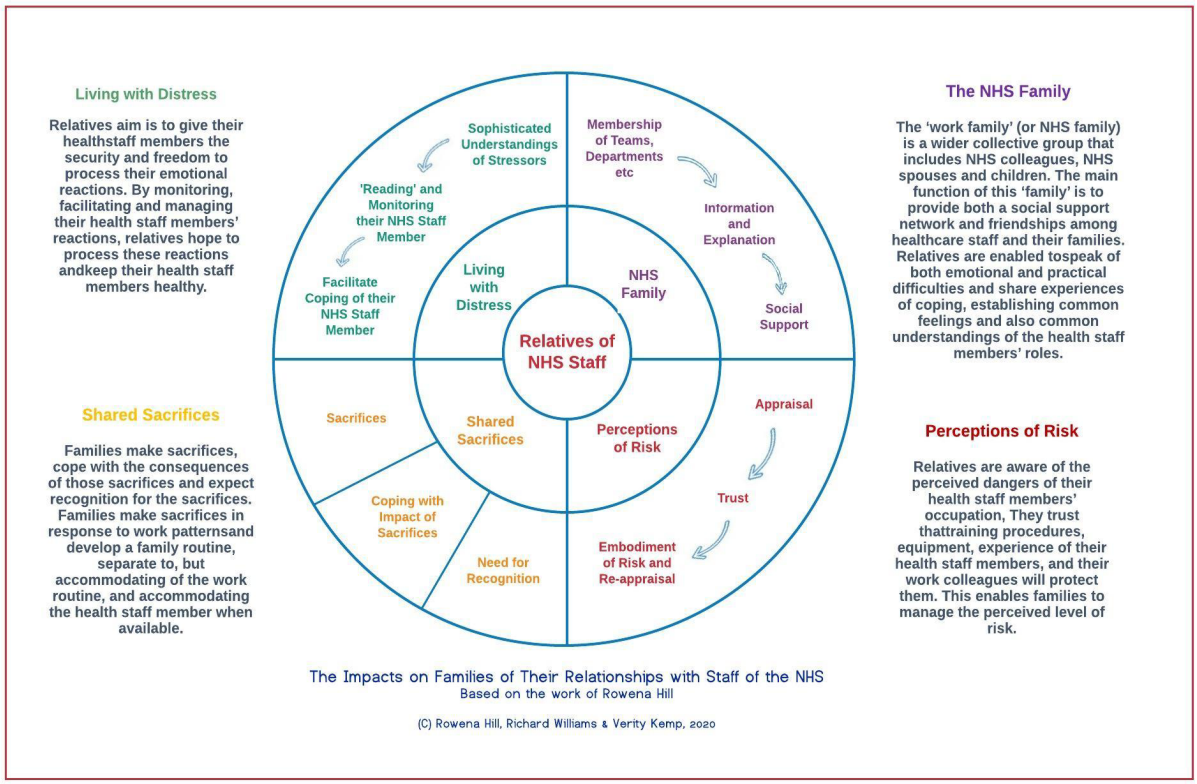
Prior to the COVID-19 pandemic, evidence from research conducted in the UK with family members of firefighters showed that:

1. Families/relatives have a strong need for their sacrifices to be recognised
2. Relatives/families avoid engaging with the perceived occupational risk of their family members, trusting in the training, equipment, and their firefighting colleagues
3. Being a relative/family of a firefighter provides a shared identity and support network
4. Families often try to undertake ongoing assessments of their relative/family member to calibrate the health and wellbeing of their firefighters.[7]

Healthcare staff may be hesitant to discuss the details and emotional impact of their work and might want to protect their families from what they have seen or felt. Evidence suggests that families can help to alleviate worries by encouraging healthcare staff to talk about the job and what it entails. Recently, we have seen acknowledgement of the impact of the changes to work patterns created by the pandemic including: changes to shift patterns; changes to the nature and pace of jobs; changes to social perception of healthcare staff's roles; changes to working practices and the pressures of restarting wider services.

Figure 2 below illustrates the impact on families of their relationships with healthcare workers. There are four principal domains: living with distress; shared sacrifices; healthcare staff members' families; and perceptions of risk.

Figure 2: The impacts on families of their relationships with staff of the NHS



Concepts Relating to Meeting the Psychosocial Needs of Healthcare Staff

Primary and Secondary Stressors

In emergencies and disasters, it has become common to distinguish between primary and secondary stressors. Primary stressors are the sources of worry or anxiety that stem directly from the events and consequential tasks that the staff face. They may reflect single events but, more often, an accumulation of pressure over time. They include decisions that staff believe are morally and/or professionally unfair. Hence, moral distress and moral injury are primary stressors of considerable current concern that have raised substantial interest during the pandemic.

By contrast, secondary stressors are 1. Social factors and people's life circumstances (that include the policies, practices, and social, organisational, and financial arrangements) that exist prior to and impact people during an incident; and/or 2. Societal and organisational responses to an incident or emergency.[8] They include the adequacy and effectiveness of employers' responses to events and their expectations of employees' performance, the career aspirations, and concerns of staff about their training, the conditions in which they work and live and their work-life balance.

The term describes conditions that persist for longer than do most emergencies. It includes: failure of infrastructure recovery, gaps in provision of services, failures in rebuilding and problems with insurance. Thus, secondary stressors include events and circumstances that limit people's recovery and adaptation and sustain adversity. Generic secondary stressors that may affect staff who work in pre-hospital environments include:

- Lack of skills or training needed to do the job
- Lack of materials (supplies, equipment) needed to do the job

- Poor role definitions and unclear expectations
- Poor organisation of work
- Lack of support at work
- Unnecessary agency policies and practices
- Unnecessarily poor working conditions
- Poor scheduling of work (long hours, few breaks, lack of leave time)
- Lack of opportunities for recreation
- Arbitrary leadership and/or management practices
- Conflict and mistrust within and between teams
- Poor communications (within teams, between agencies and management and with families).

Recurrently, staff of public organisations told the team that secondary stressors of the natures we have listed here affect them to a greater degree than do the primary stressors and the matters raised by staff who seek help very frequently concern secondary stressors.

Emotional Labour

Working with people who are affected by illness and personal problems requires emotional labour. Common experience is that, without the passion, commitment, carefully positioned relationships and emotional labour of staff, the quality of the care of patients is unlikely to be optimal both routinely and in emergencies.

Key themes are awareness of the importance of validating the emotional labour put in by staff who work with people in crises and the psychological safety they require. We know that:

- Working with people who are unwell or in crisis means doing a job that is rich in social meaning, but requires emotional labour from employees.
- People who choose helping as a career tend to believe more in the kind of work that they do than the pay they receive. But this can create vulnerability and the circumstances in which people experience moral distress.
- This work often requires intense interactions with other people and the pace and content mean it can often interfere with the ideal way that staff members would want to carry out their work.

Psychological Safety

The concept of psychological safety concerns the degree to which people perceive their work environments as conducive to taking necessary interpersonal risks when working. There is evidence that psychologically safe working environments are not only better for the wellbeing and welfare of the staff, but also less likely to result in errors of judgement or mistakes.[9] Leaders should take responsibility for creating working environments that are as psychologically safe as is possible.

Leaders play important roles in fostering environments that contain their staff's emotions in ways that are realistic and psychologically safe to enhance patient care and prepare staff for new challenges. This requires team leaders to be acutely aware of team members' psychosocial capabilities and training needs and ensure they receive professional supervision, effective management, and psychosocial support.

Collective and Personal Efficacy and Teamwork

Generally, most staff cope well and show enormous dedication to their work in challenging circumstances. They manage not only the stressors inherent in their exposure to patients' suffering and needs, and associated risks to themselves and their families, but also secondary stressors including pressure from peers, relationships, changing organisational demands, and logistics.

A sense of self-efficacy increases with staff members' experience and levels of expertise. It is an important factor in reducing levels of distress and is associated with compassion satisfaction and active coping rather than avoiding difficult decisions and situations.

Active coping includes techniques such as describing and reflecting on work done in conversations with colleagues and others. Central to work groups' abilities to cope is the concept of emotional containment whereby strong emotions can be held or contained by a group or system without members realising or having to re-experience them. This process can be supportive and assists staff to feel safe. Groups that cannot contain emotions are less supportive and leave people feeling unsafe. Staff report that active coping does work in the context of traumatic experiences.

Increasingly, commissioning and delivery of healthcare is based on collaborative, coordinated and cohesive teamwork. This is especially the case in incidents, emergencies, and other crises. Often, the term 'team' is used to describe groups of people who work together within an organisation. But, simply, working together is insufficient to define what constitutes a team and who is likely to benefit from working with other people. Crucially, there must also be a sense of shared identity that links members of teams and not just linkages based on knowing and working with one another over a period of time. This sense of shared identity creates a secure base from which to manage working environments and unlocks the potential of group members.

The concept of collective efficacy, which is more likely to distil from effective teamwork, refers to activities that groups of people focus on, the effort they put into those activities and how teams perceive their abilities to accomplish their tasks. Collective efficacy enhances job satisfaction and wellbeing. Thus, a sense of 'community at work' among healthcare staff is important to them and feelings of belonging contribute to satisfaction.

Leadership

Sustaining the personal and collective efficacy of staff and providing psychosocial care for them frames a vital challenge for leaders. Leadership is one of the most important factors in keeping staff healthy and their work effective. Good leadership improves the wellbeing of staff and reduces their rates of anxiety, depression, job stress and sick leave.

Creating and running psychologically safe teams and sustaining the resilience of healthcare staff requires leaders to:

- Be accessible and supportive
- Acknowledge fallibility
- Balance empowering other people with managing the tendencies for certain people to dominate discussions
- Balance psychological safety with accountability, physical safety and professionally safe practice and other components of strategic, corporate and clinical governance
- Guide team members through learning from their uncertainties

- Balance opportunities for their teams' reflection with action
- Have the capacity for emotional containment.

The Moral Architecture of Employing Organisations

The concept of Moral Architecture refers to the moral, ethical, human and employment rights obligations that organisations acquire in their commitment to delivering high-quality services, and as employers. It is important that responsible authorities recognise the implied psychological contract between them and the staff they employ directly or indirectly or cause to be employed.[10] These obligations should be reflected in organisations' policies, their design and delivery of services, and their corporate governance. This means that each healthcare organisation's visions, priorities, structures, activities, leadership, management, and conditions of staff employment should be consistent with its stated roles and espoused values.

THE CIRCUMSTANCES BEFORE THE COVID-19 PANDEMIC

Before the COVID-19 pandemic, many authors were focusing on the impact that the health and wellbeing of healthcare staff had, not only on them, but also on the people they were caring for and how mentally and physically demanding it is to care for people who are ill or in distress. Williams and Kemp, for example, argued that to ensure the health and wellbeing of healthcare staff, employing organisations should have a clear vision and plan for ensuring the health and wellbeing of their staff.[10]

In its report in 2018, the GMC states, 'Wellbeing is key to improving retention of doctors and quality of patient care. Better planned and resourced medical leadership can spread the positive, inclusive and supportive cultures that are evident in many places across the UK.'[11] The GMC published in 2019 its review, Caring for Doctors, Caring for Patients.[12] That review highlights that workplace stress affects doctors' health and, thereby, has an impact on patients' safety and retention of medical staff.

In 2019, Health Education England published a framework aimed at helping health and social care employers improve the mental wellbeing of their employees.[13] One of the recommendations included is to improve the mental health and wellbeing of all staff with a particular theme being to consider challenges faced by ambulance staff.

In September 2020, the BMA published its short report on the mental health and wellbeing of the medical workforce – now and beyond COVID-19 and the associated mental wellbeing charter.[14,15] The BMA charter proposes that employers build a supportive structure based on:[15]

- Building a culture that supports mental health and wellbeing
- Developing a wellbeing strategy
- Embedding health and wellbeing into line management
- Making support services accessible
- Creating safe and healthy workplaces
- Actively fostering peer support
- Supporting staff on sickness absence leave and on their return.

The report highlights that doctors often experience moral distress when there is no growth in support to match the increase in the number of patients seen and their associated complexity of needs.

Wellbeing and Mental Health Support in Emergency Services is a report based on a 2019 survey conducted by MIND.[5] The survey reveals that ambulance personnel report that only 34% rate their current mental health as being 'good' or 'very good'. Across all emergency services, 21% say their mental health is 'poor' or 'very poor' compared with 14% in 2015.

The Pre-Hospital Emergency Medicine Trainee Association (PHEMTA) conducts an annual survey of all current Pre-Hospital Emergency Medicine trainees. The survey is wide-ranging and includes issues related to wellbeing and welfare. A summary of the most recent available reports from 2017-2018 and from Spring 2020 share some common themes.[personal communication]

There were many positive themes about trainees' experiences in the surveys. Trainees usually enjoy their placements, feel well-resourced at work, well-supervised, and supported by their colleagues. They enjoy working in small, cohesive teams and feel positive about the quality of care they deliver and the impact this has on their patients and their relatives.

Due to the geographical spread of training jobs across the country in, often, remote locations, which are allocated centrally via a national application process, it is common for trainees to have to relocate or travel to take up their 1-to-2-year training post and some trainees must relocate again mid-training. Trainees frequently reported a negative experience associated with moving or staying away from home during their placements. This is related directly to the stress and financial cost of moving itself, and also to feelings of social isolation as a consequence of being away from family and social support networks. Trainees also reported the negative impact of long commutes to work; a third of trainees spent more than one hour travelling each way, often with 12-hour shifts between commutes.

A report on diversity in the PHEM workforce produced in November 2020, points to many of these same factors having an impact on recruitment to training including those trainees with caring responsibilities.[personal communication]

Many trainees also expressed financial stresses. Training can be expensive, and may include moving to a new house, buying a car, fuel costs, examinations, courses, and the cost of joining professional bodies. Additionally, pay can be unpredictable, with some trainees receiving no on-call supplements. Financial support in the form of expenses for moving and travelling is available to trainees. However, trainees often found the processes for accessing these entitlements overly complicated and onerous, and the sums insufficient to cover the additional costs of training.

Trainees recognise the effects of their exposure to traumatic injuries and suffering; however, most trainees feel well supported by their colleagues and organisations and report being well-placed to cope with these effects. A minority of trainees report feeling more emotional, or emotionally exhausted as a consequence of their work.

Furthermore, some trainees report negative experience associated with the portfolio/curriculum, that has been described in one case as being overwhelming, the level of paperwork, and number of assessments required to evidence that they have completed the curriculum and are progressing through training.

THE IMPACTS OF COVID-19 ON THE NEEDS OF STAFF

The NHS Staff Survey for 2019 published in February 2020 has a brief section on health and wellbeing.[4] It reports that 40.3% of staff felt unwell because of work-related stress in the previous twelve months and notes that this proportion has been steadily increasing from 36.8% since 2016. The BMA drew on data from ONS, NHS Scotland and the Welsh Government that indicated that sickness absence in the

NHS in England (3.4%) was twice the rate in the private sector (1.7%).[14] It was higher in Northern Ireland at an estimated 5.3%, Scotland at 5.3%, and Wales at 5.6%.

The NHS Staff Survey for 2020 reports:[16]

- The proportion of NHS staff who reported feeling unwell as a result of work-related stress increased by nearly 10% in 2020 as the pandemic took hold
- Around a third of staff (34%) had worked on a COVID-19 specific ward or area at some time, and half of staff who had done so (50%) reported feeling unwell as a result of work-related stress
- 69% of minority ethnic staff said that their organisation provided equal opportunities, in contrast with 87% of white staff who said the same. Although only 13% of staff reported experiencing discrimination at work, ethnic background continued to be the most common reason given and was mentioned by 48% of staff who claimed to have experienced discrimination.
- 33% of staff said that their employer took positive action on health and wellbeing - up from 29.3% in 2019
- 60% of staff believed that they had adequate materials, supplies, and equipment to do their work, up from 56% in the previous year's survey.

'Clinicians are working incredibly hard in the most extraordinary circumstances the NHS has ever faced, but without the right safety measures in place, they're still living in fear for their own health and the health of their families. Confidence in the system they work in is low and more must be done to regain that trust.'[17]

Clark et al developed an evidence map of wellbeing and support interventions for UK ambulance services' staff.[18] They note that before the pandemic, the NHS in the UK was actively engaged in considering the health and wellbeing needs of the workforce. Staff working in ambulance services were identified as a priority. The authors assert that this engagement is even more important as ambulance staff deal with the short- and long-term outcomes of the pandemic. The article notes that the ambulance services in the UK have particular challenges because of their need to meet performance targets including response times as well as being impacted by circumstances, such as the lack of hospital beds.

Things have changed for wider society as a consequence of COVID-19 and the measures taken, but healthcare workers and their families have been through a different experience of managing that risk. Past studies have shown that people working in frontline roles, such as firefighters, gain a lot of support from their families.[7]

THE HOUSE OF COMMONS HEALTH AND SOCIAL CARE COMMITTEE REPORT ON WORKFORCE BURNOUT AND RESILIENCE IN THE NHS AND SOCIAL CARE

This report of the Parliamentary Health Select Committee was published in June 2021.[At: https://tinyurl.com/2p8ry6dd] It reported on the workforce issues facing staff in the NHS and social care and takes account of the additional impact of COVID-19. Its conclusions are that burnout has a significant impact and negative consequences for the mental health of individual members of staff with consequent impacts on colleagues, and the patients for whom they care.

This report recommends that the NHS provides additional support for its staff that will require removing barriers to seeking help and embedding a culture in which staff are explicitly given permission and time away from work to seek help when it is needed.

PART TWO: WORK IN PRE-HOSPITAL EMERGENCY CARE

THE NATURE OF WORK IN PRE-HOSPITAL CARE

Risk and Protective Factors for Organisations, Groups and Persons

Emergency responders are a mix of people with differing capabilities, roles and experience. They face differing profiles of psychosocial risk and needs for education, training, social support, and peer support.

They may include members of the public who are first on the scene as well as frontline rescue and emergency staff, and staff providing humanitarian aid, welfare and healthcare services, and military personnel, if involved.

Healthcare staff who work in pre-hospital environments are exposed to extraordinary events and are likely to witness suffering, distress, and death, with unusually high frequency. Inevitably, some of the impacts are stressful by virtue of the enormity of other people's suffering and their injuries, the responsibilities that staff take-on, and because they may have to do demanding and skilful work in hazardous environments. These factors are known as primary stressors. They are inherent in emergencies. Thus, healthcare staff, as all responders to emergencies, are called on to cope with stressors that are inherent in the ways in which people's diseases and injuries intersect with their jobs. These inherent stressors, primary stressors, include:

- Exposure to the disease, injury, and death
- Exposure to the risks of responding by aircraft or rapid response vehicles
- Exposure to on-scene dangers
- Direct exposure to survivors' and witnesses' suffering
- Sometimes, feelings of powerlessness - inability to provide help at the level and at the time that it is needed.

A key matter is the exposure of practitioners to people who are suffering. Studies speak to the well-researched matter of levels and duration of exposure as a major risk factor for people who are directly affected and responders developing mental health problems, such as PTSD.[19] This is often referred to as 'the dose effect'. They also provide support for the observation from research into children's development that '… long-term adverse outcomes are better predicted by the total number rather than the specific nature of environmental risk exposures', which is described as the cumulative risk model.[20]

NHS Ambulance Services

The largest group of pre-hospital workers in the UK are employed by NHS ambulance services. They are made up of a diverse group of professionals which includes paramedics, technicians, call-takers, and a smaller group of nurses, midwives, and doctors. They respond on behalf of the NHS to a very broad range of healthcare emergencies, provide care in the community, and facilitate onward care and transport to and between hospitals. Ambulance services and their staff have been under a particular pressure due to the increasing demand on their services over the past decade. This has coincided with large scale changes to the structure of ambulance services, including the merging of smaller organisations into larger regional or national bodies. There are specific indicators that this workforce is under pressure which manifests as:

- Low morale and low engagement with NHS staff surveys
- High staff sickness and turnover rates compared with other NHS organisations
- Perception of relatively poor pay by staff
- Relatively high rates of harassment and bullying.

Helicopter Emergency Medical Services (HEMS)

A smaller group of clinicians, which includes paramedics and doctors, work in highly specialised HEMS units, responding on behalf of NHS ambulance services to high acuity incidents and major incidents. These units are often well-resourced and are often partly funded through charitable donations. National surveys of clinicians working for HEMS units have emphasised the positive aspects of this working environment, which includes:

- Working closely with colleagues in highly developed teams
- Working in an open culture, in which scrutiny and learning are encouraged
- The many formal and informal opportunities to debrief the incidents, and to process their feelings
- Close supervision and support during training
- An ability to influence and effect organisational change.

The Challenges of PHEM Training

The Pre-hospital Emergency Medicine training programme was introduced in the UK in 2012. It recruits senior doctors in training from emergency medicine, anaesthesia, acute medicine, and intensive care medicine to a 1-year full-time training programme, which if successfully completed, results in sub-speciality accreditation. Trainees are seconded from NHS hospitals to work for HEMS providers alongside paramedics and ambulance organisations.

Trainees face unique challenges during their training in addition to their clinical work; they must cover an extensive curriculum, conduct a relatively high number of workplace-based assessments, and pass a series of rigorous national examinations. Trainees are recruited centrally from across the UK, and often have to relocate due to the limited geographical spread of posts. There is no administrative and limited financial support available for relocation. Operational bases are often in remote, rural locations, far from base hospitals, resulting in long commute times; 30% of trainees spend more than 1 hour commuting each way. Shifts are long, between 10-12 hours, and shift intensity is unpredictable and may finish late. It is unsurprising that a challenge in training, frequently cited by trainees, is a feeling of social isolation.[personal communication]

The PHEM training programme is still relatively new and trainees often describe insecurity regarding future job prospects on completing the programme. Some trainees need to complete specialty training in their base specialty after finishing PHEM training, but there is no current mechanism for guaranteed continued PHEM work. Trainees often describe feeling ‘adrift’ and worry about both skill maintenance and future employability.

Evidence shows that responders are likely to be at higher risk of the psychosocial and mental health consequences of their involvement in incidents and emergencies compared to the general public who were not directly involved. However, most of the material that is included in this guidance applies to staff of all healthcare and allied organisations. The distress that staff experience and the dysfunction

and disorders they risk are similar to the conditions that affect survivors of incidents and emergencies. Yet, staff may feel stigmatised by recognising or showing the emotions they experience and any problems they develop. Staff who experience distress that persists for more than two weeks should receive assessments of their needs.

It is vitally important that staff of healthcare and allied organisations are enabled to work effectively in challenging circumstances of a wide range that may generate incidents and emergencies including those related to road traffic collisions, pandemics and epidemics, high consequence infectious diseases (HCIDs), and terrorist incidents.

Single-session stress debriefing and brief interventions that ask people to re-experience the events that they have survived should be avoided. NICE states that psychologically focused debriefing should not be offered for preventing or treating PTSD.[21]

COMMON EXPERIENCES OF PHEM PRACTITIONERS AND TRAINEES

This section explores experiences that the team found to be common in practitioners and trainees. Distress is the most common of them all.

Distress

There are two broad approaches to defining distress. First, some of the literature refers to distress being comprised of symptoms of anxiety, depression, or post-traumatic stress disorder. This is not the way in which the term is used here. The Programme Team recommends using distress in relation to mental health during and after emergencies to depict people who have a range of experiences that are anticipated, and usually much broader than symptoms of common mental disorders. Thus, many accounts characterise potential experiences into emotional, cognitive, social, and physical domains. [22,23]

The clinical workload experienced by PHEM practitioners is challenging cognitively, emotionally, and psychologically and this is especially true for less experienced providers, such as many of the PHEM trainees. Trainees are frequently exposed to situations in which there is a high level of expressed emotion and visually unpleasant scenes, which are commonly regarded as emotionally challenging and distressing. Accidents and injuries in which children and young people are involved can be particularly distressing as can witnessing the consequence of brutal interpersonal violence or deliberate self-harm. However, many clinicians adapt to working in this unusual environment and find that their involvement in delivering high-quality care has a protective effect.

Exposure to specific situations, which resonate with a person's experiences and life circumstance or fears, can be particularly prone to causing distress and the injustice in the world can prove difficult to comprehend and to process. Situations in which trainees feel they have made a mistake or underperform also have the potential to cause distress. Central to PHEM are robust clinical governance processes. While they are crucial for learning, it is an adjustment for some trainees who may not be used to having their performance put under such scrutiny. It is important to recognise that distress is a common, anticipated and, usually, temporary human experience. But it should be handled well. It is not usually helpful to tell colleagues that their experiences are normal as that may lead to feelings of invalidation.

Many secondary stressors have been described in PHEM practice, mostly by PHEM trainees. Over the course of the last five years, PHEMTA surveys have highlighted recurring and common themes. They

include trainees' concerns about their practical exposure (i.e., their lack of the quantity and breadth of clinical experience and worrying regarding disparities and regional variations i.e., that others are doing more) and not having sufficient experience or evidence to pass the Training Assessment Panel (TAP) as a result. This can also result in feelings of working beyond one's competence and fear that supervision is not always consistent. There is also a large burden of assessment both through Workplace-Based Assessment (WPBA), in which varying ability or willingness of appropriate seniors to complete the assessments compounds the issue. In addition, these WPBAs must be mapped to an extensive curriculum which is time consuming. Many trainees feel that this time could be spent more productively by undertaking simulation practice or debriefing cases, for example.

Examinations add to the stress that trainees experience with two sets of postgraduate PHEM sub-specialty exams to be taken, which are usually in addition to parent specialty exams. All are taken over a relatively short space of time and some trainees have described up to ten exam components over an eighteen-month period.

Furthermore, isolation is a common term used by PHEM trainees. Most PHEM trainees move away from home, their families, and friends for placements. Many programmes only have one or two trainees in a region and forming support networks is challenging. Trainees have described their PHEM training as incurring considerable personal costs, mostly in terms of personal and social life, but there is also a significant financial burden associated with moving or staying away from home.

Caring Responsibilities and Parental Leave

Due to the geography of PHEM training programmes, it is not unusual for trainees to commute long distances from home, and some have to relocate. This causes a particular problem for those trainees with caring responsibilities, including those with young families. This may go some way to explain the current gender imbalance in pre-hospital care, which was highlighted in the report into diversity (see below).

Less than full time training has become more established in many services. However, arranging childcare around long shifts, at antisocial hours, with often unpredictable finish times can be source of significant stress for PHEM trainees. As yet, there is very little literature on continuing HEMS work during pregnancy. Therefore, PHEM practitioners often find themselves grounded on informing employers of their pregnancy.

Fatigue

According to a model by Williamson et al.,[24] there are three main sources of fatigue:

- Working at unfavourable times of day (the circadian factor)
- Short sleep prior to shifts and/or prolonged wakefulness before shifts (the homeostatic factor)
- Task-related factors (the physical and mental task demands).

Shift working, as is common in pre-hospital care, causes a disturbance in the natural sleep-wake cycles and disrupts people's circadian rhythms. This is true in night shift working. Shift workers typically accrue a *sleep debt* as sleep during daylight hours is reduced in both quantity and quality. Sequential night shifts compound risk; over four nights, sleep debt is equivalent to having lost a whole night of restorative sleep. Therefore, it is not surprising that pre-hospital care providers and many other clinicians consistently describe high levels of severe fatigue.

PHEM trainees often work beyond their contracted hours with long shifts and long commutes without accommodation near to base. Night working can be particularly taxing for people who work in services that operate 24/7, yet many trainees do not have access to adequate rest facilities. These experiences leave trainees short of rest.

Job cycles can be extremely lengthy and are both mentally and physically demanding. Task load, mission duration, complexity, perceived difficulty and perceived performance can all increase fatigue, even for people who are as well-rested as possible prior to a mission. There is also evidence from the retrieval industry that the aeromedical environment presents additional fatigue risks including:[25]

- A hypobaric environment, hypoxia, and decreased humidity
- Turbulence, vibration, and noise
- Discomfort arising from cabin layout and sustained relative immobility
- Irregular lifestyle; especially relating to sleep cycle and family life
- Repeated changing of teams, climate, culture, work, and off-duty routines.

Helicopter missions may be even more fatiguing than when working on fixed wing or road platforms. Environmental factors known to be highly fatiguing in all operational settings include noise levels, extremes of temperature, and vibration. Responding by road can also be fatiguing. Long drives and navigation to scenes under blue light conditions across a large catchment area requires a breadth of geographic knowledge and this can increase perceived task load and, thereby, fatigue.

Shift-work and resultant fatigue carries a significant psychological morbidity. Shift workers, particularly those people who work at night, have higher rates of insomnia, anxiety, depression, chronic fatigue, and burnout. Fatigue has also been shown to impact on personal relationships outside work.

Moral Distress and Moral Injury

The concept of moral distress was outlined by Jameton in 1984 in his book Nursing Practice: The Ethical Issues.[26] It refers to the effects of knowing what should be done for a patient but being unable to do so because there may be situational and organisational constraints including lack of time, staff, or equipment.

Moral injury has been described in two ways. First, by Shay as, betrayal of what is right by someone who holds legitimate authority in a high stakes situation,[27] and, second, as the result of: 'perpetrating, failing to prevent, bearing witness to or learning about acts that transgress deeply held moral beliefs or expectations'.[28] A morally injurious event might take many forms, and there is ongoing research to understand what might constitute a morally injurious event.

Earlier, this report has described the potentially adverse impact of PHEM training on social networks and the resulting isolation. After a morally injurious event or series of events, the symptoms that are manifested tend to follow a pattern. This pattern revolves around shame and guilt, with a person's concomitant withdrawal from social networks, thus creating isolation. The cognitive models of PTSD conceptualise symptoms as the result of the interactions of the mind with extreme fear in which the sufferer appraises the world as an unsafe place in which terrible things can happen. By contrast, the concept of moral injury suggests that the mechanism of action might be more closely related to feelings and thoughts about shame and guilt, that is, the world is a *wrong* place, in which terrible things are *allowed* to happen. Researchers point out that the guilt and shame felt tend not to extinguish over time if emotions are not effectively processed.[29]

Valuing Staff, Valuing Patients

Understanding the psychological harms of workplaces through a social psychological lens means that moral injury can be understood as happening to a person, but it also affects teams, and affects the meanings shared in teams and work settings. There is no equivocation in the literature around these various topics, social support is extremely useful in mitigating the psychosocial impact of working in healthcare [7, for example].

PHEM has a strong tradition of regular debriefing, flat hierarchies and teamwork which may go some way to mitigating the effects of moral injury as does leadership. In his initial understanding of moral injury, Shay discussed the role of leadership and how bad decisions by leaders leave subordinates at risk. This is a useful reminder to leaders of PHEM of their roles in ensuring that their decision-making is transparent and that trainees feel safe enough to ask for clarity about leadership decisions and to ask for support. The importance of leadership is described in more detail later in the report.

Trainees' Experiences

This section begins with a reflection on a case as it impacted a PHEM trainee. It is followed by vignettes describing the experiences of two other trainees. These personal experiences provide rich illustrations of the impacts of primary and secondary stressors.

A Reflection

This is an anonymised, personal reflection written in the first person. It includes a vivid description of a trainee's experience of attending the scene of a road traffic collision.

> As pre-hospital practitioners, we are exposed to extreme situations nearly every day. The emotional burden of this vicarious trauma is cumulative and often unnoticed. We do not enter this career choice blindly - we know pre-hospital medicine doesn't come with a happy ending as often as we'd like. However, the highs of saving a critically ill or injured patient are worth it, and one good case is like a tonic that can keep us going with optimism.
>
> I have been surprised at the cases that have affected me the most. It tends to be lower-key cases, those that catch you out when you let your guard down a little, when you're tired and contemplative.
>
> And so, it was that 'Unknown female, Friday One' caught me off guard. It was a cold morning, but bright with a low winter sun. Perfect for flying, the landscape glistening with morning dew. We had been dispatched to a road traffic collision; no further details given. The land crew arrived as we approached the scene overhead and, from a distance, all seemed calm.
>
> Rotors off, frosty breaths as we huffed and puffed the kit bags over the fence and down the road. Our patient, who had been out jogging, had been hit by a car. It was immediately evident she was seriously injured. Her face was bloody, her airway compromised, and her head swollen. She didn't have any identification on her, but as we rolled her over, I saw a reflection of myself. My doppelganger was here in front of me. Same age, same build, same height, same hair - I drew breath, and continued with medical treatment.
>
> Following a pre-hospital anaesthetic and flight to hospital, she was registered at hospital by a standard nomenclature. She was an unknown female patient; it was Friday, and she was the first trauma patient. A rapid whole-body CT showed a devastating head injury. She was already beginning to autonomically dysregulate. Just as we were leaving hospital, the

police brought in her husband - who appeared blissfully unaware of the impending devastation.

'Unknown female, Friday One' died in Intensive Care 18 hours later. I wept for her family, her husband and young child and what had been lost. I cried for all the patients I have treated that I could not save. I cried for myself. It could have been me and it felt somehow like it was me.

Two Vignettes

Here are two anonymised vignettes. Trainee A describes the professional and personal toll of asking for psychosocial support. Trainee B describes the personal and organisational compromises needed to be able to participate in and complete the PHEM training programme on top of their caring responsibilities.

Trainee A

During their PHEM training, Trainee A was living alone, hundreds of miles from their social support network. Trainee A says, 'I worked two circadian-rhythm-destroying rotas (pre-hospital and my base specialty) and all the additional demands of training (exams, portfolios etc) eroded away my resilience. It left me feeling like I was always running on empty. In addition, the PHEM work, was unsurprisingly emotionally taxing with little recovery time.

I knew I needed support, which I described at the time as psychological support. I delayed seeking support because I feared being judged or excluded from clinical practice and, when I did with the help of a colleague, I was really struggling and briefly unfit for work. I took some annual leave. I was ready to return to work, but found my fears realised as I came up against significant barriers.

Organisational lack of experience of employees with similar problems and a paternalistic system dictated that I could not work and had no say in the matter. It was mandated that I see one of the Deanery leaders, a psychiatrist, and two different occupational health services. Apart from having to repeat myself and relive my experience multiple times, not one of these people had any knowledge of the PHEM aspect of my job. I had to start by describing what my job involved and most were shocked to hear what an average day involved. While I understand the vital importance of patient safety and the need to ensure clinicians are safe, I found the process of proving I was fit for work more distressing than the original event. My job was a large part of my self-identity and my colleagues had become my new social support system. However, I could not work until this process had been completed. Now, more isolated, and more frustrated, I felt powerless.

During this time, I argued that the same process would not have been followed if I had a medical problem requiring time off work but was told I had no choice in the matter. Rather than help me recover, it made me more guarded about my mental health and less likely to seek help in the future.

Trainee B

B is a PHEM trainee with a child who has complex needs. During their PHEM training they commuted over 3 hours a day from home. B quickly became fatigued and worried that this impacted their performance. After crashing their car mid-way through training, B started

booking a B&B several nights a week. This, in addition to the antisocial hours and intense shift pattern, caused strain on B's personal relationships, as B attempted to arrange specialist childcare and hospital appointments around PHEM training. In addition, B felt overwhelmed by the administrative burden of PHEM training, completing much of the expected assessments and revision for exams in their own time.

Despite this commitment, B worried about their job prospects at the end of PHEM training and felt increasingly insecure in their career. Although B thought that colleagues might have picked up on their distress, no one talked about it, and no one offered support.

B felt there was an expectation that they should just get on with it. The feeling of isolation and lack of support was exacerbated by working in a service that was new to them, miles from home, and staying away much of the week, B felt increasing isolated, and didn't know who to talk to. B experienced several difficult taskings during their PHEM training which were morally injurious, after which appropriate support, including TRIM, was offered. However, there was no support for the secondary stressors that were so evident during B's training. This caused B to question their ongoing career in PHEM and with the service.

A Commentary on the Reflection and the Vignettes

The editors of this report believe that these three accounts are representations of experiences that are not uncommon in the professional lives of many other trainees. Whatever our specialties and roles in healthcare, we all work in a system that either directly or indirectly encourages stoicism, and which appears to us to make difficult early disclosure of emerging difficulties. This tension comes through in the account from Trainee A. Often, the discouragement may be felt by practitioners more keenly than people around them wish and intend.

While the culture of PHEM Is based on teamwork, and huge support and care emanates from this system, there is still more to do to reduce the stigma that staff feel, and which may impede them from disclosing their experiences.

The reflection provides a clear account of how events may trigger responses in practitioners that surprise them. It describes one aspect of how the primary stressors affect practitioners but, all-too-often, events strike people emotionally in unpredictable ways. A lot of practitioners describe accumulation of stress over time and indicate how triggers or hooks of a personal nature may become the last straw that precipitates them into distress. All of us are vulnerable to hooks that come through our own lives. Thus, the practitioner in the reflection identified with their unconscious patient based on superficially similar physical characteristics.

In not dissimilar terms, Trainee A describes their work in PHEM as 'unsurprisingly emotionally taxing with little recovery time'. The taxing nature of the work is a primary stressor, but the small amount of recovery time is not. It is a secondary stressor that should be tractable. Trainee A's account of the problems they had gaining support while retaining their sense of personal efficacy and the way in which they perceived that apparently restricted way in which the educational system responded exposes the potential for less-than-optimal responses. Thus, there are, apparently, risks of the professional accountability, performance management and welfare systems overlapping in ways that may risk compounding people's problems. Perhaps, a tendency to elide the governance and disciplinary frameworks with the approach to caring for staff reflects senior staff feeling uncertain about caring for colleagues in a world that focuses on maximising patients' safety? Each of these features of modern practice is a good thing, but how do we help more senior staff and clinical leaders to feel as comfortable with supporting colleagues as they do with decision-making in their practice?

Certainly, the Programme Team is not complacent about the importance of protecting the public. Nonetheless, it seems to us from this account and many other informal discussions we have had with practitioners that it is important to create staff welfare, wellbeing and psychosocial and mental health care systems that have clear pathways into and out of them. It is very important that staff are able to retain a sense of agency and self-efficacy as they use the services available to them. We advise that there should be clarity between the roles and actions of disciplinary, professional accountability, performance management and care systems.

Trainee B describes the secondary stressors that may impede trainees' progress and cause suffering that is far from necessary. Both trainees anticipated that the PHEM training over and above their base specialty training would be personally and professionally challenging, but their placements required them to be away from family and friendship sources of emotional and physical support at a time when they were working at full stretch in long shifts to practise new knowledge and acquire skills while giving of themselves in demanding situations.

Thus, we conclude that both primary and secondary sources of stress are alive within PHEM training. Reflection with trusted colleagues is an important aspect of dealing with primary stressors but we also invite the responsible authorities to visit how the secondary stressors, which are potentially tractable, might be better managed. We have experienced senior members of the professions within pre-hospital care as very keen to develop and improve care for trainees and established practitioners and anticipate that this goodwill and the positive intentions of senior staff are a very good basis from which to progress.

An Outline of Ways of Responding Immediately to Staff Who Become Distressed

It is important to recognise that stress and distress are common reactions and not usually harbingers of pathology. That is probably because working in small teams over long shifts provides opportunities for natural conversations and peer support. It is important to develop a culture wherein people feel valued and safe and can form relationships with their colleagues. This also emphasises an important principle of having psychosocially informed conversations embedded within organisations' cultures.

Most PHEM trainees say in the PHEMTA surveys that their employing organisations care about their wellbeing and are supportive. There are employee assistance programmes available and signposting clearly displayed within organisations.

Most PHEM organisations have rigorous governance processes in which cases are scrutinised in a systematic way. These case reviews often involve a technical debrief and discussion of cases in detail and the experience is often valued highly as conveying learning. However, there is the potential for this type of reflection to create situations in which clinicians are expected to recount the events of an incident and to re-live difficult or distressing events in front of peers, colleagues and supervisors. There is evidence that 'emotional debriefing' of this nature has the potential to cause harm and that it should be avoided. Therefore, it is important to understand and select cases for open peer review in cognisant and sensitive ways.

Validation and Invalidation of People's Experiences

People who are affected by emergencies and incidents regard social and professional acknowledgement of their experiences as key to their recovery. This process is called validation and describes recognition and affirmation of a person's distress. Often, colleagues and family members are those most important sources of validation. Authoritative validation is that aspect of validation and establishing entitlement to care offered by a person who is perceived to have specialist knowledge or expertise in relation to the

psychosocial impact of major events. It emphasises the importance of ensuring that opportunities are created for other people, whose opinions are respected, to recognise and acknowledge their experiences. Authoritative validation confers positive connotations on a person's distress and their wish to seek support. It challenges negative self-evaluations (i.e., people seeing their distress or seeking help as a sign of weakness or inadequacy). Research shows that it is all too easy to invalidate people's experiences by using words such as 'normal'. That word may be interpreted as the listener not being interested. Supervising staff and colleagues should develop ways of listening to each other and reflecting that minimise the risks of invalidation.

After the Canterbury New Zealand earthquakes of 2010-2011 the impact of measures to enhance employees' wellbeing was tracked. It suggested that attention needs to be paid to longer-term recovery of staff. This included validating employees' and managers' efforts and flexibility during a crisis.[30]

The Importance of Listening

Not being listened to makes people feel undervalued. On the contrary, active listening, that is, making a conscious and practised effort to hear not only the words that another person is saying but, more importantly, trying to understand the complete message being sent, is core to helping to support the health and wellbeing of colleagues. It is suggested that:

- 85% of what we know we learn from listening
- 45% of our time is spent listening
- A person recalls 50% of what they have just heard and only 20% of it is remembered long-term.

Listening skills can be improved with practice. Part 5 offers links to resources.

The Importance of Leadership

Managers and team leaders have a core role in addressing the impacts of stress on the workforce of their organisations. In the first instance, managers and team leaders should be mindful of their own needs. They need access to sources of care and support to be able to manage the stress of their own roles. Responsibilities for other people are acknowledged as bringing additional stress.

Managers and team leaders can champion the approach to wellbeing in their organisations and help to embed it into the culture. This involves creating a culture of safety both from systems (aviation/clinical) but also emotionally (it is okay to speak up, and admit one's fears, weaknesses, mistakes, and uncertainty and to express emotion). It is important that leaders are familiar with key concepts relating to psychosocial care of their staff and that they can shape the culture of teams and environments that are psychosocially informed and safe. People should also lead by example and it is important for leaders to share examples of mistakes they have made and to be open about their weaknesses. This is powerful modelling that encourages other people to behave in open ways that support wellbeing. Furthermore, it is important that leaders address issues as they arise and focus on clinical excellence rather than entirely on timings.

Enabling Staff to Access Support

Staff may find it difficult to consider seeking support. The Programme Team suggests that managers and team leaders and their organisations have a responsibility to ensure that staff can access support when they are concerned about their own wellbeing or that of colleagues. Access to wellbeing services is aided by:

- A clear description of services being offered, with entry points being well-defined and signposted, and a description of the people at which each element of the service is aimed
- A clear statement that confidentiality of people accessing services will be respected and that that access will not affect their professional roles
- All efforts should be made to facilitate access to services by, for example, allowing time to use services. IT access should be facilitated.

DIVERSITY AND PRE-HOSPITAL EMERGENCY MEDICINE

A report on diversity in the PHEM workforce produced in November 2020 for The Intercollegiate Board for Training in Pre-Hospital Emergency Medicine reported on the data from national recruitment for PHEM sub-specialty training posts. It points to issues regarding gender. It also identifies the impact of secondary stressors on the workforce including the need to relocate to be able to take up placements, which deters people with caring responsibilities from applying to join the PHEM workforce in the first instance.

The key points highlighted in the report include how difficult it is for some people who would wish to enter PHEM training to gain the necessary pre-application clinical work experiences. Other barriers to application concern branding and role modelling. The perceptions of many people are that PHEM practitioners, especially those in visible leadership positions, are white, male, macho - 'a helicopter hero'. People who are non-white and non-male tend not to apply. Action has been taken since 2018 to refocus recruitment by, for example, supporting projects that showcase the diversity within PHEM, monitoring recruitment data and focussing on recruiting people from Black and minority heritages.

RESEARCH CONDUCTED FOR THIS REVIEW

This section summarises a research study that was initiated to underpin this report. It continued through the pandemic. While the analysis of the data gained is not yet complete, this text that follows is a summary of the study. More information will be published once the work has been completed.

A Systematic Review: The Psychosocial and Mental Health Impacts of Working in Pre-Hospital Care

This systematic review of the literature is intended to answer the following questions:

- What are the psychiatric and psychosocial consequences of working in pre-hospital care?
- What factors have been identified that could be causative, or could contribute to these impacts?

The review searched for research publications pertaining to clinical or non-clinical employees working in pre-hospital healthcare, such as ambulance crews, pre-hospital physicians, and dispatchers. The studies have investigated the psychosocial impact of the work undertaken by these healthcare professionals, including psychiatric and psychological disorders, mental health symptoms, trauma, suicide, social problems, and work-related stress responses such as burnout or exhaustion.

The systematic review was prospectively registered, and the full methodology can be found on the PROSPERO website.[1] Each stage of the review employed appropriate and independent consideration and screening of materials identified.

The initial search of the literature identified 6,365 citations. After duplicates had been removed, full texts were obtained of the remaining papers. Screening of those papers identified 359 papers as suitable for further review. Of these, 169 papers (published from 143 separate studies) met the criteria for inclusion in the review. Critical appraisal of these papers commenced. This process is summarised in the Prisma flow diagram reproduced as Figure 4 at the end of this section.

One hundred and thirty-two (132) papers reported quantitative research. There were 16 qualitative papers, 9 mixed methods papers, 11 reviews, and one case report. The most common methodology reported was cross-sectional surveying. The team did not set a date limit on the literature search, and the earliest publication included was from 1988. Figure 3 shows that the number of publications per year has fluctuated but clearly trending upwards over the past decade. Studies have been conducted around the world, but the majority were conducted in Westernised countries (e.g., UK = 22, Australia = 19, USA = 17, Canada = 13).

Figure 3: Publications per Year

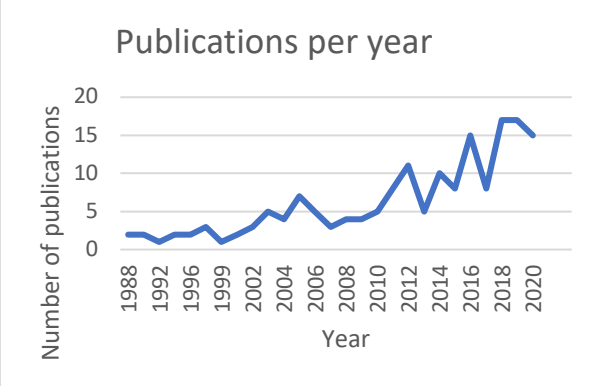


Table 1: Number of papers relating to outcome

Quantitative Outcome Recoded	Number of Papers
Occupational functioning	58
Post-traumatic stress symptoms	56
Emotional symptoms	30
Stress	26
General health & psychopathology	21
Distress	11
Alcohol & substance use	10
Resilience	10
Physical symptoms	9
Quality of life	7
Leaving	6
Wellbeing	6
Relationships	5
Suicide	3
Suicidal ideation	2
Diagnoses	2
Prescription of psychotropic medication	2

Many different professional groups working in pre-hospital medicine were studied, the most common were paramedics, EMTs, dispatchers, nurses, and doctors. A general description of the outcome the research sought to study was identified and recoded into the groups listed in Table 1 above. Few studies utilised clinical interviews or medical histories to identify the prevalence of participants meeting criteria for diagnosis with psychiatric disorders, and most used questionnaires to screen for symptoms. This methodology limits the conclusions that can be drawn.

Quantitative Measures and Outcomes

The most common topic studied was occupational functioning. Many studies used the Maslach Burnout Inventory (MBI), which is a validated self-report questionnaire that is designed to assess burnout as defined by the World Health Organization. There was a wide variety of other items used including

[1] www.crd.york.ac.uk/PROSPERO/display_record.php?RecordID=157165

authors writing their own questions that were unvalidated. The second most common topic of enquiry was to measure symptoms of post-traumatic stress disorder. They were explored using a variety of screening questionnaires. Symptoms of depression were the most screened for emotional reactions and a variety of tools was used. Anxiety and stress were among other factors screened, again using a variety of tools.

Qualitative Measures and Outcomes

Thirteen qualitative papers were critically appraised. All the papers report on the experiences of ambulance services staff over the course of the last two decades. The majority report on staff in the UK, North America, and Australia. Most papers are based on individual interviews. Two papers combine an analysis of individual interviews and focus groups, and one paper is limited solely to focus groups. The papers use a variety of analytic methods. Thematic analysis is the most common (6), followed by content (3), narrative (1), and phenomenological analysis (1). In one paper, the method is insufficiently specified to be categorised, and although one paper reported the methods as qualitative, this was not judged to be an accurate statement by our reviewers because the authors summarised the content of free text boxes from a quantitative survey study. Three papers were deemed to be of high quality, three of low quality, and the remaining papers were judged to be moderate.

Based on the qualitative evidence available, the following themes were identified:

1. Dispatch personnel experience significant distress associated with stressful working conditions (such as high call volumes, difficult calls, lack of resources). This was compounded by organisational stressors, for example being under-appreciated and inadequate support. It is important for employing organisations to fully appreciate what dispatch staff contribute and also the strain they work under and to adjust practices and procedures to enhance support.
2. Frontline ambulance staff report experiencing distress following certain types of critical incident. This is associated with incidents that are particularly poignant that invoke high compassion and/or inability to help. Feeling unable to help undermines professional self-esteem and induces self-blame.
3. Ambulance staff perceive barriers to accessing support. Public recognition that they do a difficult and stressful job and authoritative validation from superiors of their actions in response to critical incidents are important in facilitating coping. Coping was reported as moderated by workload pressures (e.g., long hours), receiving social support from peers, families and friends and the ability to emotionally detach from distressing events.
4. Staff retention is affected by stressful working conditions (e.g., long hours), and inadequate training and management support.
5. A range of very long-term, serious impacts on psychosocial function and physical health were reported by ambulance staff in the wake of the 9/11 terrorist attacks.

Conclusions

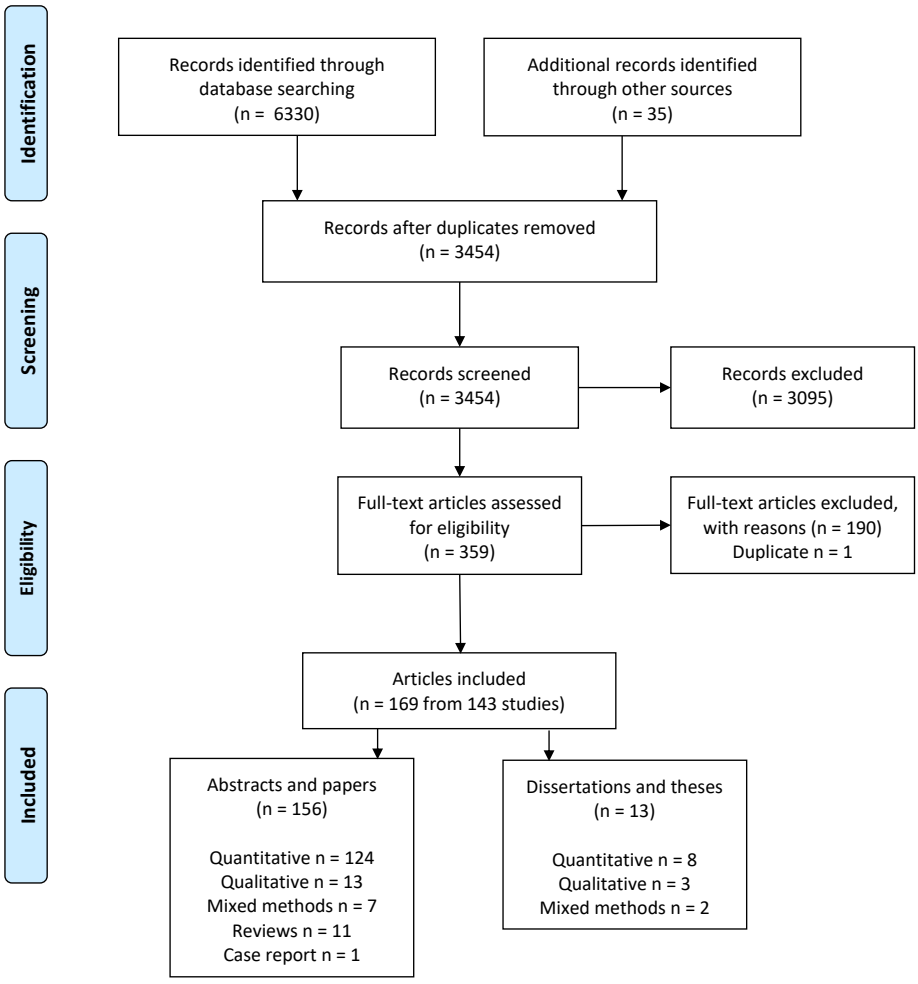
This systematic review has revealed that considerable interest and resource has been directed towards the concern that practitioners who work in pre-hospital environments may develop burnout and psychiatric disorders, including post-traumatic stress disorder, as a result of attending critical incidents.

However, the methods used in most of the quantitative studies were not able to answer the questions we set out to consider. Most used cross-sectional surveys and self-report questionnaires, which are not diagnostic tools, with convenience samples. In our opinion, it is likely that they considerably overestimated the incidence of the problems they set out to measure. This is illustrated by the one high-

quality study that conducted clinical interviews and found that only a small percentage of employees met the criteria for PTSD or major depression, and that most resolved over a few months.

The high scores on these questionnaires perhaps indicate that pre-hospital practitioners suffer considerable stress and distress. The sources of this stress are not likely to be, as has often been thought, attending unusual and high-profile incidents, but daily organisational and operational hassles such as having unsupportive managers and a high volume of work despite lack of resources. Many pre-hospital practitioners do experience fatigue and burnout but continue to attend work anyway, aided by support from friends, families, and their teams, and in the knowledge that they are doing a well-respected and important job.

Figure 4: PRISMA flow diagram



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *P*referred *R*eporting *I*tems for *S*ystematic Reviews and *M*eta-*A*nalyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit www.prisma-statement.org.

PART THREE: INTEVENTIONS FOR STAFF OF PRE-HOSPITAL HEALTHCARE SERVICES

CARING FOR STAFF

Core Approaches to Caring for Staff

This part of the report describes core approaches to caring for staff, key elements of that care and it proposes a model of care for caring for staff. We start by identifying 15 overarching or golden approaches and then state an important matter of principle, The Psychosocial Approach.

15 Overarching Golden Approaches to Caring for Staff

Overall, there are 15 overarching Golden Approaches for public sector organisations. Implementing them is Recommendation 1 of this report. They are to:

1. Provide clear messages about the priorities of work and care for staff within organisations
2. Ensure every employee has a person or a place to which they can go for immediate support and ensure staff have space and time for reflection (an example might be a buddy system among colleagues)
3. Ensure that work is based on effective teams and that team cohesion is supported by employees training together
4. Develop care pathways that link the wellbeing, psychosocial and mental health aspects of the organisations' workforce plans into the clinical and governance roles in pre-hospital care
5. Ensure that leaders are effective and supportive to enable people and develop team cohesion
6. Intervene early with staff who are distressed – this requires strengthening the working environment, and listening rather than providing, for example, therapy or counselling
7. Adopt a practical approach to early intervention based on the acronym **PIES**; that is to provide interventions in **proximity** to where people work, with **immediacy** and **expectation** of recovery and by using **simple** interventions first – there is evidence that this approach lessens the risks of staff members developing mental health disorders later
8. Learn and use active listening skills
9. Seek out and remedy secondary stressors
10. Ensure that employees are offered opportunities for integration with their peers because social support is key
11. Remember that colleagues' senses of personal efficacy and agency are important features in their recovery
12. Consider Peer Support programmes because they bring staff in departments and teams together and may prevent development of more serious problems
13. Be clear about who will and will not benefit from a 'medical' approach (a minority of people may develop diagnosable mental health disorders for which they require specialised medical care, but most do not)
14. Support staff in the face of negative public perceptions

15. Get workplace culture right: the actions and policies in this list are all critical to creating environments at work that are conducive to staff giving of their best. This means that policies and actions for supporting staff must be separate from those for staff discipline and performance management.

The Psychosocial Approach

Williams and Kemp have created what they call The Psychosocial Approach.[22,23] Informed by Patel [31], it describes:

- Distinguishing people who are distressed from those who require biomedical interventions
- Basing distinctions between the two sorts of conditions on trajectories of people's stress levels and dysfunction
- Providing assistance for the greater number of distressed people through lower intensity psychosocial care.

Information and Risk Communication

Delivering good psychosocial care is critically dependent on effective communications within and between teams and between the agencies involved in the responses to incidents and emergencies. This is fundamental to high-quality responses. Similarly, research shows that good communications with the people who are affected and with members of the wider concerned public are fundamental to sustaining their resilience, and to building the public's opinions about the legitimacy of the responders and their authorities. The trust the public gives to first professional responders and their co-operation with advice from authorities turn on good communications.[32]

Resource Gaps

One of the presumptions made in this report is that providing care for people will usually be from existing services. However, there are instances when event-specific services may be required to ensure that care is provided for people at risk.

If resource gaps develop, people at risk of developing mental disorders consequent on events may not be recognised. Research on people's recovery trajectories makes it clear that their risk of developing mental disorders is likely to extend well beyond the period in which specific relief services are available. Many people involved in the Manchester Arena bombing in May 2017 have been followed up. This has shown that distress among the public involved was universal and that it persisted in a substantial proportion for two years or longer. Relatively, few staff of the emergency services responding to the Manchester Arena bombing came forward in the first year and research to ascertain the experiences of staff is underway. While it might be tempting to assume that this occurred because staff were less affected than the public, the history of 9/11 suggests otherwise. The impact of that event on emergency responders reached a peak around seven years afterwards. Therefore, we emphasise in this report that services for supporting staff after emergencies and incidents should be sustained for rather longer than many people might first think to be appropriate.

THE THREE AGENDAS OF CARE

The recommendations from our review are presented in a format that is consistent with the approach used by the Stevenson-Farmer Review (see Figure 5). The British Medical Association's charter proposes that employers develop a supportive structure based on:

- A culture that supports mental health and wellbeing
- A wellbeing strategy
- Embedding health and wellbeing into line management
- Accessible support services
- Creating safe and healthy workplaces
- Actively fostering peer support
- Supporting staff during sickness leave and on their return.[15] We recommend a strategic approach that takes account of these principles.

Figure 5: Employers can provide support for all employees to thrive, and more targeted and tailored support for those who may need it (Stevenson and Farmer 2017) (© Crown copyright 2017: reproduced under the Open Government Licence v3.0)

A Strategic Approach to Improving Care for Staff

The Programme Team proposes a framework to improve the health and wellbeing of people working in pre-hospital settings. It is summarised by the model of care in Figure 6.

As we have already seen, the Stevenson-Farmer Review of mental health and employers concerns all organisations and it identified that the human cost of poor mental health is huge through impacts on the lives of employees and people around them at work and home. Reports cited earlier by the BMA, the GMC and Mind Blue Light as well as the NHS Staff Survey emphasise this.

The model of care in Figure 6 below follows the categories identified in the Stevenson-Farmer Review.

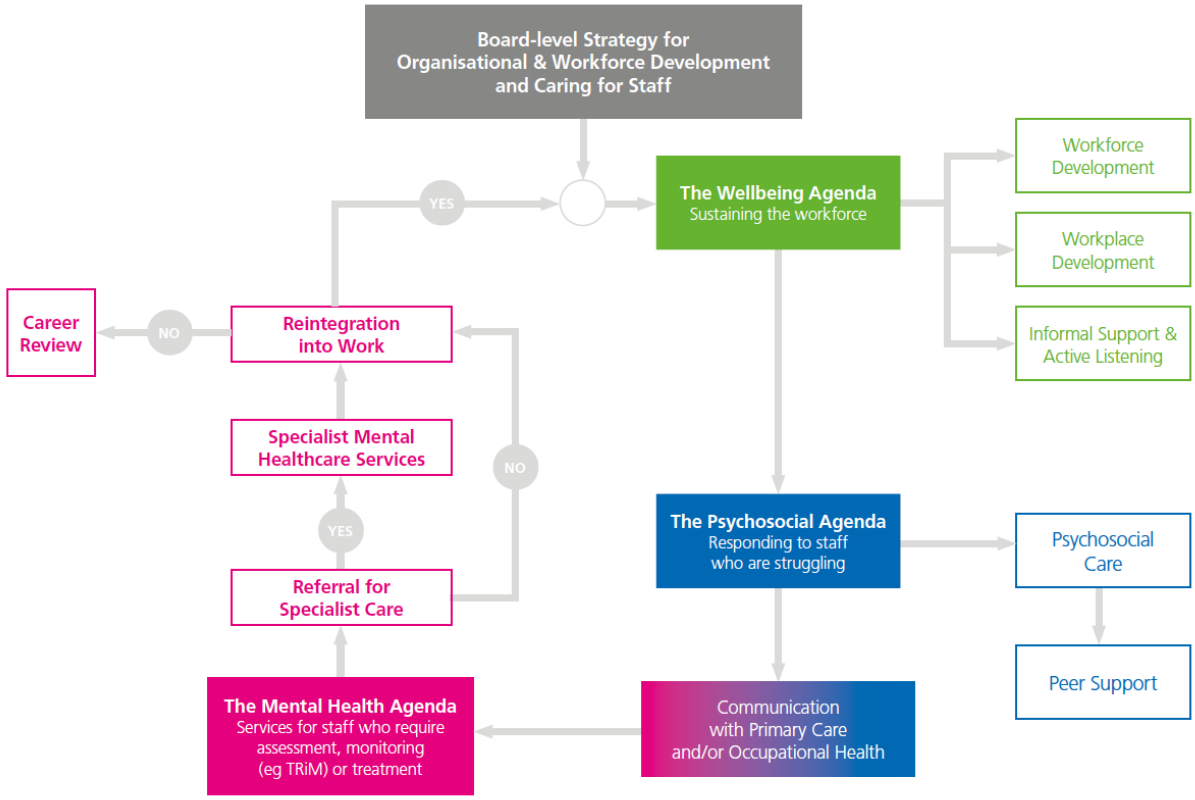
Planning

Planning is important. It can sustain staff through an emergency or the declaration of a major incident. The three agendas we describe in our model apply both to unusual circumstances and 'business as usual'. This model suggests core actions to support mental health and wellbeing in staff for these situations. Careful attention to this is important throughout emergencies. Experience from many situations is that emergencies cause unusual primary stressors and accentuate the impacts of secondary stressors.

Valuing Staff, Valuing Patients

Psychosocial care is intended to sustain people in the aftermath of an incident or emergency, and reduce their distress, suffering and risk of developing a mental disorder. It should be available to anyone who is affected by an incident, including those people who are distressed or have mild mental health needs. It can be delivered by non-specialist health practitioners. Practitioners who deliver it should be supervised by people who have experience of, or are trained in mental healthcare.

Figure 6: A model of care © R Williams, V Kemp, 2021 all rights reserved



Mental healthcare should be available to anyone who has moderate to severe mental health needs, including, importantly, people who have a diagnosed mental health problem or disorder. These interventions are usually delivered by specialists who work in mental health services, Improving Access to Psychological Therapies (IAPT) services, and mental health services for adults (AMHS). It is important that there are locally agreed and tested care pathways that ensure that members of PHEM staff can be referred for mental healthcare after incidents.

The psychosocial care and mental healthcare responses to the direct and indirect impacts of incidents and emergencies must be well coordinated and planned so that people can obtain the right help at the right time and to:

- Ensure psychological safety
- Provide information for the public about people's reactions to incidents
- Distinguish people who are distressed and require psychosocial care from those who also require mental healthcare
- Offer early intervention and active outreach to minimise distress and reduce the numbers of people at risk of developing longer-term mental health problems
- Provide lower-intensity psychosocial interventions to the substantial numbers of staff who are likely to be distressed

- Provide more specific interventions (e.g., evidence-based psychological interventions) in a timely and effective manner for people assessed as needing them
- Recognise the important role that GPs have in identifying people in need (including the public and professional practitioners), monitoring, and supporting people affected, and recognising when and how to refer them to specialist services.

These responses should involve:

- Integrated planning and service delivery
- Timely and agile responses
- Restoring physical and psychological safety for people and communities
- Delivering a culturally appropriate approach
- Enabling choice and control (agency) for survivors and their families
- Active outreach
- Evidence-based interventions
- Collaboration with the NHS and non-NHS sectors
- Evaluating outcomes and cost-effectiveness.

Planning key approaches should include:

- Families of staff
- Establishing the initial support (roles and actions) to be delivered by people whose symptoms persist and screening for those people thought to be at greater risk of developing a mental health problem.
- Providing clear and consistent messages and routes of communication to all key stakeholders regarding key approaches and access to support, including responses to any anticipated major incidents or emergencies.
- Approaches that are evidence-based and proportionate, flexible, and timely.
- All psychosocial and mental healthcare responses being provided:
  - As part of a multi-agency response
  - Within a clear governance framework
  - To support coordinated delivery of care that manages key interfaces and transitions seamlessly
  - By professional practitioners, managers and staff who are appropriately qualified and have access to training, good leadership, support, and supervision.

People reading this report should be aware that:

- A common but erroneous assumption is that everybody involved in an emergency or incident needs counselling or psychiatric treatment in the immediate aftermath of a major incident.
- Social support is a natural and powerful intervention.

Single-session stress debriefing and brief interventions that ask people to re-experience the events that they have survived should not be practiced because NICE states that psychologically focused debriefing should not be offered for preventing or treating PTSD.[21]

NHS England has recently published guidance that includes many of the features included in this report: Responding to the Needs of People Affected by Incidents and Emergencies.[33]

PRACTICAL APPROACHES TO INTERVENING

Service-level Principles

Achieving improvements in care for staff in pre-hospital care requires the employing organisations to ensure appropriate cultures in order to achieve the objectives and provide compassionate care for their staff.

At the level of delivering services day-to-day, the core principles of the approach are to:

- Agree and disseminate definitions in frequent use to ensure there is common understanding (See Part 5)
- Orientate services to staff members and their families in the varied cultures in which they live, relate and work
- Translate lessons from evidence and experience into plans and frameworks for delivering wellbeing, psychosocial care and mental healthcare.
- Integrate plans for the wellbeing, psychosocial care and mental healthcare agendas into all policies.
- Ensure that communications are effective because they are fundamental to sustaining the integrity of services and reassure staff
- Emphasise social connectedness and social support in creating comprehensive programmes
- Work to agreed minimum standards that take account of the range of circumstances that might be encountered.

Managing Employees' Stress

It is important that healthcare organisations take active steps to sustain their employees. These steps include refining the processes of managing and leading staff by recognising their emotional labour, augmenting opportunities for teamwork and providing staff with social support. These organisational interventions create and maintain organisational cultures in which attention to quality of care can flourish, and in which staff are sustained and developed so that they continue to gain satisfaction from their emotionally difficult work and are available for future events.

Earlier in this report, the three agendas of care were described. They are described again below with an emphasis on those people who are working in pre-hospital environments.

Training for Professional and General Managers

A paper in Lancet Psychiatry reviews the impact of a well-constructed random controlled trial of a four-hour training programme for commanders of firefighters in Australia that aimed to increase their confidence in speaking with staff about wellbeing and mental health.[34] The research showed that this intervention led to a significant reduction in work-related sickness leave and a return of £10 for every pound invested.

After the Canterbury New Zealand earthquake sequence of 2010-2011 the impact of measures to enhance employees' wellbeing was tracked. It suggested that attention needs to be paid to longer-term recovery of staff. Targeting employees' wellbeing and psychosocial needs is a low-cost strategy that can ensure positive functioning through a lengthy recovery period. It benefits the organisation and individual members of staff.[30] It recommends that managers should:

- **Validate** employees' and managers' efforts and flexibility during a crisis
- Give more **autonomy to local managers**
- **Use flexible performance management** by giving local managers discretion to enhance performance and create a learning culture for a variety of reasons including the evidence that better psychological safety tends to reduce mistakes.[30]
- **Focus on the wellbeing and psychosocial care** of employees

The Wellbeing Agenda

The Wellbeing Agenda focuses on the importance of supporting staff who are thriving to continue to do so. It recognises the pivotal role of team leaders and managers as well as those people with responsibility for organisational policy, to develop teams by focusing on:

- Addressing people's physical healthcare needs
- Continuing to develop leadership
- Strengthening teams, team membership and teams' cohesion
- Offering Schwarz Rounds (modified to suit pre-hospital settings)
- Ensuring preparedness, training, and support for staff so that they are always able to look out for each other
- Ensuring that every member of staff has a 'buddy' to whom they can turn for support
- Ensuring that every member of staff has a person or place to which they can go to receive support in a timely way
- Ensuring that staff have space and time for reflection and recovery
- Seeking and addressing organisational and workplace factors that impact on people's physical, social, and work capacities
- Reducing secondary stressors
- Continuing to work on reducing stigma.

In order to maintain the wellbeing of those people who are coping well with the demands of working in pre-hospital care, organisations should support their employees to deal with a range of challenges such as:

- Sleep and shift work
- Transition from one role to another (e.g., trainee to consultant) and across the working lifespan
- Life transitions such as parenthood, the menopause, bereavement
- Physical health and especially back pain
- Drug and alcohol use
- Bullying

- Mental health – awareness of how to protect one's mental health.

People's relationships can either support or undermine their resilience. Their abilities to form and maintain relationships with others at home and work, as well as with strangers at times of greatest need, and to accept support are key strengths. These social relationships are powerful influences on how people cope with adversity, ill health, and emergencies. People who show good outcomes tend to perceive that they have, and do receive, support.

Everyone and every organisation involved in planning for and responding to incidents and emergencies should understand how people may react to emergencies and incidents. They must also understand the factors that affect how well people cope, including the importance of relationships, social support, leadership, and care (see the Annexes in Part 6).

The Nature of Social Support

Social support is based on people perceiving that they have good social networks that offer them support. It promotes people's wellbeing and recovery in many settings.[7] Social support 'consists of social interactions that provide people with actual assistance that also embed them in a web of relationships that they perceive to be caring and readily available in times of need'.[35,36] It includes emotional, informational, and operational components.

The Psychosocial Agenda

The number of people affected may be very substantial despite the fact that the majority of distressed people are unlikely to develop a mental disorder. Intervening early can reduce the risks of their developing disorders later. Psychosocial care emphasises responding to the needs of staff by focusing on:

- Strengthening the contributions of teams and enabling members to actively listen to and support each other
- Developing peer support [37]
- Providing mental health training for professional and general managers [34]
- Setting workplace cultures to recognise and augment post-traumatic growth - that is positive psychological changes experienced as a result of adversity and other challenges that give rise to higher levels of functioning
- Work according to the principles of psychological first aid to provide psychosocial care with the intention of:[38]
  - Reducing the risks of morbidity
  - Reducing absence through sickness
  - Reducing the risks of presenteeism
  - Promoting personal growth & learning.

Practical interventions are best provided using the **PIES** approach. Two good studies show that its adoption reduces the risks of people developing mental health diagnoses later. It calls for psychosocial care interventions to be offered: in **Proximity** to where staff work; with **Immediacy;** in **Expectancy** of good outcomes; and using **Simplicity** of interventions.

But organisations are advised to avoid routine screening because there is little evidence that it conveys benefit inside organisations.

Psychological First Aid

One approach that is an important component of psychosocial care is psychological first aid (PFA). The principles of PFA are identified as being central to psychosocial interventions for the public and staff during and in the immediate aftermath of incidents and emergencies. PFA is not a single intervention or treatment.[39] As originally described, the basic objectives are to:

- Establish a human, compassionate and non-intrusive connection with affected people
- Enhance people's immediate and continuing safety
- Provide physical and emotional comfort and calm for overwhelmed people
- Establish people's immediate needs
- Offer practical assistance and information
- Connect survivors with social support networks
- Support adaptive coping
- Clarify availability of services and signpost survivors to sources of help, assessment and further intervention.

PFA recognises that:

- Attending to basic needs (safety, security, food, sanitation, shelter, interventions for acute medical problems, etc) is the first and highest priority
- People affected by incidents and emergencies require rapid, effective action followed by sustained service responses that may require medium- and long-term mobilisation of resources
- Organisations and services should understand people's preferences for informally provided support, but also their needs for responsive formal services
- The emphasis of psychosocial universal care (see below on page 48) should be on empowering affected people and communities, and restoring their agency
- The public should be actively engaged in delivering responses to communities' and people's psychosocial needs after disasters and major incidents
- The public must be trusted with accurate information that is provided regularly by credible persons, because the public should be regarded as part of the response and not solely as part of the 'problem'
- Formal services should be made available that offer psychosocial care interventions whose needs are not met informally by their families and colleagues.

Peer Support

Peer support is an intervention that describes a supportive relationship between people who have experiences in common. Peer support is rooted in the knowledge that 'hope is the starting point from which a journey of recovery must begin'.[40]

Peer supporters can inspire hope and demonstrate the possibility of recovery. They are valued for their authenticity because they can relate to the challenge. They draw from their experiential knowledge - the happenings, emotions, and insights of their experiences - as they listen to and interact with peers who seek their help.

More information on peer support can be found in a document prepared for the FPHC.[37]

Universal, Selective and Indicated Psychosocial Interventions

Psychosocial interventions are categorised as universal, selective and indicated:

- **Universal psychosocial interventions** are intended to offer primary prevention. They should be started as soon as possible, within hours of each incident's impact, and should continue to be available for months afterwards (i.e., into the recovery phase). Universal psychosocial interventions should be readily available to staff of the emergency services. They should:
  - Be family and community orientated
  - Be based on the principles of PFA
  - Address people's practical needs, their relief from distress and aim to build community coping and support.
- **Selective psychosocial interventions** should be offered as public mental health interventions to groups of people who are identified as being at higher risk of developing mental disorders. People should be assisted to identify and resolve, if possible, any persisting secondary stressors that may be maintaining their distress and dysfunction.
- **Indicated psychosocial interventions** should be offered to people who, after an initial personal screening of their experiences and needs, are found to have either persisting distress that is accompanied by dysfunction, or whose assessment suggests that they have symptoms of a mental disorder that do not reach diagnosis.

Universal and selective psychosocial interventions may be offered without or before assessment of people's personal needs.

Currently, the evidence for many popular psychosocial interventions is regarded as thin though it is improving in strength as research becomes available. However, more techniques need to be developed and evaluated. Nonetheless, universal and selective interventions, based on the principles of PFA, are unlikely to cause harm. The guidance on PFA also draws attention to the evidence for the positive impacts of social integration and social support on people's health.

This situation becomes more critical when designing and delivering indicated psychosocial interventions. Internationally, the SOLAR programme has recently published evidence for the effectiveness of a focused indicated intervention for adults whose needs fall short of requiring treatment for mental disorders.[41] Similar testing and validation work is in hand relating to children and young people.

The Role of TRiM

Trauma Risk Management (TRiM) is a type of peer support that was developed in a military setting to support military personnel after traumatic events.[42] It is important that research continues into the effects of this intervention in civilian services and to understand its scope and limitations.

The Role of Occupational Health Services

Occupational health (OH) is a specialist clinical service that aims to provide benefits for staff and organisations as well by contributing to the productivity of organisations through investing in the health and wellbeing of their workforces.

In 2019, NHS Employers produced a guide to ensure that NHS organisations are clear about what they should expect from their OH service and how to ensure the service works to enable staff to deliver safe

effective and efficient patient care.[43] It commented that, where NHS organisations prioritise staff health and wellbeing, performance is enhanced, patient care is improved, staff retention is higher, and sickness absence is lower. There is also evidence that access to good OH support improves staff engagement and can contribute to cultural change.

Additional standards relating to their ability to deliver six 'core' services is required of OH Services delivering care for the NHS. This consists of:

Prevention:	Preventing ill health caused or exacerbated by work
Timely intervention:	Early treatment of the main causes of absence in the NHS
Rehabilitation:	A process to help staff stay in or return to work after illness
Health assessments for work:	Supporting organisations to manage attendance and retirement
Promoting health and wellbeing:	Using workplaces to promote improved health and wellbeing
Teaching and training:	Promoting the health and wellbeing approach among all staff and ensuring the availability of future OH staff

The Mental Health Agenda

The mental health agenda focuses on responding to the needs of staff whose needs indicate that they may require specialist mental healthcare by:

- Ensuring access to occupational healthcare to enable staff in need to receive assessments of their needs
- Creating service level agreements with specialist mental health providers to ensure ease of access for certain staff for timely and reliable mental healthcare.

SUSTAINING STAFF IN CHALLENGING CIRCUMSTANCES AND CRISES

Planning is important to sustaining staff through an upsurge in activity caused by occurrence of an emergency or declaration of a major incident or a single incident. The advantage of the three agendas identified in this report as at the core of the approach recommended to meeting the psychosocial and mental health needs of staff is that they apply to both unusual circumstances and business as usual. Careful attention to the wellbeing and mental health of staff is important throughout emergencies.

Experience from the COVID-19 pandemic is that that emergency hugely accentuated the impacts of secondary stressors.

Preparation as Crises Begin

Supporting teams to prepare for what is to come means providing anticipatory briefings and critical information that should enable people to feel in a better place to understand what is likely to happen and how they might respond. An example of a psychosocial briefing is provided by Williams et al.[44]

Preparation means:

- Providing information about the feelings that people are likely to have in preparation for potential distress that they may experience
- Reducing anticipatory anxiety by sharing what may happen

- Being honest and open about what is happening, and why - this helps to reduce the risk of moral distress and injury
- Enhancing knowledge of and support from managers
- Focusing on leadership, teamwork and team cohesion is critical
- Preparing a range of interventions for people who become distressed and making sure that all staff know how to access them.

TRAINING IN PSYCHOSOCIAL CARE

The Programme Team recognises that putting in hand the recommendations and promoting the learning gained from the Psychosocial Care and Mental Health Programme represents a vital though substantial investment for pre-hospital organisations. Nonetheless, the Programme Team recognises that there is substantial further work required to turn this investment of time and money into improved care for FPHC members including trainees, and all pre-hospital responders.

The Programme Team considers that it is axiomatic to the approach outlined in this report that the FPHC should work in conjunction with other bodies, such as the IBTPHEM, to ensure that all trainees are fully cognisant of and trained in all the components of the PHEM training curriculum pertaining to psychosocial care and mental health. Members of the Programme Team have attended the training modules offered to PHEM trainees and believe that more substantial steps are required to continue to raise the quality of training on these topic matters.

A key principle is that the FPHC should become self-sufficient in being able to retain within it the knowledge and skills accrued by the programme. This requires training of members and trainees in the knowledge and skills required to deliver psychosocial and mental healthcare. The Programme Team, therefore, recommends that the FPHC should consider ways to deliver the training that is required. Core to maintaining the momentum is for FPHC to appoint a senior person to be the Psychosocial and Mental Health Lead who should report at intervals to be determined to the Executive Committee of FPHC. An additional way forward might include appointing a training team.

The FPHC should appoint members who can be developed to deliver training on Peer Support for members of the FPHC. They should be capable of delivering advice on the evidence-base as well as how to implement and structure a Peer Support Service in pre-hospital bases across the country. The material includes:

- The evidence that underpins Peer Support
- How Peer Support works
- When Peer Support should and should not be used
- Handling matters of confidentiality
- Knowing how to escalate if something expands beyond the remit of Peer Support
- Key practical matters in initiating a Peer Support Service
- The teaching involved – lectures/slides, how to teach this course by Zoom, breakout sessions, how to keep people engaged and keep them on course in their learning.

The Programme Team offers to train approximately 10 volunteers drawn from the FPHC in the knowledge and skills required to discharge these functions and to supply the training aids to support the volunteers. The aspiration is that the volunteers would become able to cascade training to existing members and aspiring members of the of FPHC.

PART FOUR: OVERVIEW AND RECOMMENDATIONS

AN OVERVIEW OF THIS REPORT

This report includes an overview of the origins and impacts of the stress that affects trainees and staff working in pre-hospital settings. There is a body of surveys and reports that shows that the human cost of distress and mental health problems experienced by staff employed in healthcare settings is huge for many people, and extends to their colleagues and families. People who work in pre-hospital care are susceptible to these impacts.

The Programme Team and its leaders conducted a huge amount of fieldwork by visiting practitioners and services and attending conferences. They have also participated in the Phase 1 and Phase 2 Training Courses for trainees in pre-hospital emergency medicine. They are aware that the PHEMTA Surveys indicate that there are many positive themes in the experiences of doctors training in pre-hospital care. Usually, they enjoy their placements and feel well resourced, well supervised, and well supported at work. They also feel positive about the quality of care they deliver and recognise the positive impact this has on their patients and families. Nonetheless, those surveys also identify persisting problems that adversely affect trainees' experiences. Many of those matters are what this report shows to be secondary stressors that could be reduced in a pliable employment system.

The work of the Programme Team has been punctuated by the pandemic caused by the SARS-CoV-2 virus. Although the team kept going throughout that emergency, many members have been, rightly and reasonably, preoccupied with the clinical realities of the pandemic. However, we have also learned a great deal from the pandemic about psychosocial and mental health matters as they pertain to healthcare staff and the application of approaches to sustaining staff during the pandemic that had appeared of similar importance to the Programme Team before the pandemic and has provided valuable learning that can be applied equally during non-pandemic times

There is an increasing body of literature showing that the impact of the coronavirus pandemic is adding to the distress felt by staff working in healthcare settings. The COVID-19 pandemic has created a huge focus on the experiences and many ways in which the circumstances have affected staff. Large numbers of staff have reported enormous fatigue. Some staff members have clearly been distressed. It is too early to know how long those experiences will last and how many staff have developed mental health disorders as a consequence of what they have been through. We require longitudinal research of high-quality design to discover the answers to these questions.

In the meanwhile, we have been forcibly struck by the applicability of the material contained in this report, much of which reflects work performed prior to the pandemic, to supporting and caring for staff of the NHS during the pandemic. The Programme Director has been an adviser to NHS England and NHS Improvement throughout. The pandemic has allowed the director and project manager to test components of psychosocial care with practitioners and to bring forward and begin evaluation of one particular intervention that is increasingly popular - Peer Support. They have tested it with teams in pre-hospital care and intensive care units and created a one-day, team-based, online training course in the modality.

THE RECOMMENDATIONS

There are 12 primary recommendations in this report. The first is an overarching set of 15 golden approaches to supporting the wellbeing of staff and there are 11 recommendations about achieving what is required in designing and delivering psychosocial care.

Recommendation 1: The 15 Golden Approaches

There are 15 key matters that are imperatives for all organisations in any approach to caring for the wellbeing of their staff. They are based on a psychosocial and non-medical approach to meeting most people's needs and appear in full on page 39 of this report.

Recommendation 2: FPHC and IBTPHEM should work to highlight the welfare issues likely to affect those people who work in pre-hospital environments and promote positive moral architecture in their own and employing organisations

This recommendation relates to an important contribution that the FPHC and IBTPHEM could make to improve care for practitioners of pre-hospital care. It is that of adopting an active stance of continuing to advocate for improvements in the care of, and support for trainees and permanent staff in all pre-hospital disciplines. The Programme Team recognises that the FPHC is not in a position to directly improve that support and care across the system because staff are employees of healthcare bodies that have the primary responsibilities for the welfare, wellbeing, and mental health of their staff. Nonetheless FPHC and IBTPHEM can act as exemplars and advocates of good practice in the psychosocial field.

The FPHC is well-placed to advocate for high standards of staff care with employers and to ensure that all reasonable efforts are taken to educate members and potential members of the FPHC about what is required. It is also able to act as an exemplar of good practice by setting standards for employers to follow and is able to advise employers about what is required.

It is important for the FPHC to recognise that there are three major tasks in tackling this recommendation:

- First, all members of the FPHC and senior staff in services should be mindful of their own needs and model awareness of the common experience that responsibilities for other people may bring additional stress.
- Second, managers also need sources of care and support and there is good evidence from a randomised controlled trial that small investments in educating managers in being able to hold discussions with staff and recognise the pressures on them can bear large dividends. Senior staff should model attention to training for professional and general managers.
- Third, senior staff and professional bodies have important opportunities to influence the cultures of their organisations and workforce and to embed an approach to all three agendas proposed in the Stevenson-Farmer Report as elucidated in this report.

In these ways, the FPHC could be instrumental in leading culture change within hospitals and in pre-hospital organisations that should be reflected in reductions in sick leave and in improved wellbeing and mental health of their staff.

Recommendation 3: FPHC should encourage employers of PHEM practitioners and trainees to take steps to reduce primary and secondary stressors to a minimum

This recommendation concerns recognition that it is now commonplace to separate the circumstances and events that are stressful into primary and secondary stressors. They are common to all organisations. Primary stressors tend to receive the greatest attention in practice and research. However, experience and emerging research demonstrate that secondary stressors are not only potent but often amenable to improvement. The PHEMTA surveys show that many of the matters that impact

trainees are secondary stressors and that they are tractable, and most are neither implicit in events nor immutable.

While primary stressors are very powerful in pre-hospital working environments, there are also many sources of secondary stressors and the PHEMTA Surveys have well illustrated them. There may be a tendency to consider them of lesser importance but that would be a serious error because secondary stressors may be more impactful causes of problems for staff and an active plan is required to remove them, if possible, and mitigate their effects if removal is not achievable.

However, secondary stressors including, for example, having to move a substantial distance from home during training, create a significant psychosocial impact. Trainees also experience financial stress; the training itself is expensive including, for example, the cost of joining professional bodies, payment of examination fees and course fees. In addition, there may be costs associated with moving to a new house, buying a car and so on. Employing organisations should take steps to identify and mitigate the secondary stressors placed on their staff.

The report to IBTPHEM on diversity in the pre-hospital workforce also points to the impact of secondary stressors on the workforce and, indeed, that they deter people with caring responsibilities from applying to join the workforce in the first instance.

Dealing with the secondary stressors such as those identified here is no small task but doing so would produce a substantial reduction in the negative pressures on trainees and trained practitioners.

Recommendation 4: FPHC should recognise that cohesion and leadership are vital to good care of staff

There is copious research to support conclusions that working in well-led, coherent groups is a very important aspect of getting right the culture of health and social care organisations and is likely to offer strong protection for the wellbeing of staff. This means being clear about:

- The nature of leadership that is required
- Being clear about the importance of being offered a buddy and access to a place and person to which staff can go if they are stressed
- The importance of supporting peer groups.

There is much that the FPHC should do to act as an exemplar of good and effective leadership and to focus on testing and creating models for teams. Matters such as these could be topics in conferences and teaching offered.

Recommendation 5: FPHC should encourage pre-hospital organisations to adopt a non-medicalised approach to improving care and support for staff. This should be balanced with opportunities for signposting staff in greater need to more specialised health services

The problems that affect staff of pre-hospital care services are often not indications that staff have developed or are developing mental disorders. This reveals a problem with terminology and the huge potential for misunderstandings about the meaning of terms such as welfare, wellbeing, psychosocial care, and mental healthcare. This confusion contributes to some people's reluctance to accept support and to stigma. This report endeavours to set straight these matters. But FPHC is recommended to take a clear position on these matters.

This report recommends that the main approach to caring for staff should be non-medical, which should be made readily available. Everyone should have access to facilities that are able to support staff in flourishing and gaining satisfaction and invaluable positive experiences from their work. A number of staff may be distressed by their experiences at work or the conditions in which they work. They may require access to focused responses to their needs of, usually, a non-medical nature.

However, it should be recognised that a small proportion of staff may develop mental health problems of more serious natures that may require specialist assessment and treatment. There should be no complacency about this possibility and the non-medical facilities that offer psychosocial care should be capable of signposting people in need to more specialised services as early as possible and, possibly, through occupational health services.

It is only when staff are thought to need mental healthcare for a diagnosable disorder that their circumstances should be medicalised. Only, a minority of staff is likely to be in these circumstances, but they require ease of prompt access to skilled assessments and, possibly, mental healthcare.

Recommendation 6: FPHC should encourage pre-hospital organisations to adopt a stepped approach to caring for staff

This report proposed FPHC to adopt a single, stepped approach to the care of staff and their trainees that is capable of being embedded into other organisations with people working in pre-hospital care. This consists of: a wellbeing agenda for all; psychosocial care for those people who are struggling and/or distressed; and agreed pathways for people who are or appear to need specialist mental healthcare. The Programme Team recommends that the FPHC should adopt this approach or a similar one as policy.

We also draw attention to the potential for people to grow that can be augmented by attending to the three agendas described here.

The Stevenson-Farmer Review of mental health and employers shows that the human cost of poor mental health is huge through impacts on the lives of employees and people around them at work and home. It highlights the higher rates of mental health problems and suicide for employees in certain work settings. The report recommends that employers foster and support good mental health by attending to three challenges:

- **The Wellbeing Agenda***: assisting employees to thrive at work.* Wellbeing is about feeling good and functioning well and is influenced by each person's experience of life.
- **The Psychosocial Agenda***: supporting staff who are struggling.* Psychosocial care describes interventions for people who are distressed or struggling or have symptoms of mental health problems that do not reach a diagnosis whether or not they also suffer social or work dysfunction.
- **The Mental Health Agenda***:* enabling people whose needs appear to go beyond struggling to access mental healthcare, recover and return to work.

In brief terms, this means that staff in pre-hospital care and their employers should implement this approach so that it offers to staff:

- Interventions to sustain the wellbeing of members who are thriving and enable them to move on towards flourishing through engaging members in their own emotional and cognitive development
- A programme of workplace development that:
    - Is informed by awareness of the kinds of primary and secondary stressors that members face
    - Endeavours to reduce the primary stressors to a minimum

  - Responds to and remedies the secondary stressors that impact members
- A plan for developing teams and teamwork and integrating personal, team and workplace support programmes
- Recognition of the nature and impacts of secondary stressors and reducing their impacts on members
- Peer support services for members who are struggling
- Ease of access for members who may have more serious and persistent problems to specialised mental healthcare.

Recommendation 7: FPHC should appoint a psychosocial and mental health lead to ensure that progress is made on delivering the wellbeing, psychosocial and mental health agendas among FPHC members

The Programme Team recommends that FPHC should appoint a lead to carry forward the work of the programme into the future by disseminating the learning gained during the programme's work. The Programme Team has offered to train FPHC members in the theoretical and practical matters that are key to disseminating the knowledge and skills required.

Recommendation 8: FPHC and the IBTPHEM should urge the employing and regulatory organisations to review how trainees in pre-hospital emergency medicine are selected and allocated to placements

It appears to the Programme Team that this recommendation frames an important opportunity to revisit and revise aspects of the way in which trainee posts in pre-hospital medicine are allocated and advertised with a view to improving certain problems that trainees drew to our attention. We recommend that steps be taken to improve gender equality and to reduce how training placements are allocated in order to reduce trainees working at great distances from their homes and families. We recognise that these are challenging matters but recommend that active steps be set in course.

The House of Commons report on Workforce Burnout and Resilience in the NHS and Social Care was published on 8 June 2021. Its conclusion contains the statement: 'The emergency that workforce burnout has become will not be solved without a total overhaul of the way the NHS does workforce planning.'

This report refers to the research showing isolation, including having little or no access to family and social networks and poor opportunities to create professional networks, has a detrimental and cumulative effect on people. PHEM trainees and practitioners who have contributed directly and indirectly to this report, have described vividly the impact of having to take up training posts at a significant distance from their homes. Not only does this put physical demands on the trainees such as the fatigue caused by commuting long distances, but it also makes social demands on trainees who often feel isolated. In addition, there is a financial burden for many in terms, for example, of the costs of travel, accommodation, and childcare.

The report to IBTPHEM on diversity highlighted that not all regions offer PHEM training which results in some trainees having to move house temporarily or commute long distances to undertake sub- specialty training. Of the nine training regions, not all offer training in PHEM for the four base specialties and some only offer posts to EM trainees. A review of the online adverts for the 2020 training posts, showed only 2 out of 9 regions advertised that they offer Less Than Full Time training. There is also great variation in the Scheme of training offered: whether Scheme A/B (requiring two years potentially out of

region) versus Scheme C (one-year OOPT). The report on diversity states that this demonstrates inequitable access to PHEM training depending on the region of training or base specialty. It also has the potential to introduce more inequity for trainees who have caring responsibilities and cannot move from their current region. The diversity report includes in its recommendations that PHEM training scheme should be developed in the long-term in all regions across Health Education England. This programme supports that recommendation.

Recommendation 9: FPHC should encourage pre-hospital care organisations to promote knowledge of the scale and impact of the exposure of their staff to distress arising from their work

Healthcare staff who work in pre-hospital environments are required to do demanding and skilful work in hazardous environments. They are exposed to extraordinary events and may witness suffering, distress and death, with unusually high frequency. Inevitably, some of the impacts are stressful by virtue of the enormity of other people's suffering and their injuries.

Recommendation 10: FPHC should encourage pre-hospital care organisations to promote knowledge about the emotional labour ordinarily carried out by their staff

A substantial amount of emotional labour is implicitly required by pre-hospital healthcare professionals who regularly support patients and their families through suffering and distressing events.

Recommendation 11: FPHC should encourage pre-hospital care organisations to promote knowledge of the evidence showing that responders are likely to be at risk of the psychosocial and mental health consequences of their involvement in significant emergencies and major incidents

The distress that staff experience and the dysfunction and disorders they risk are similar to the conditions that affect survivors of significant and major incidents. Yet, staff may feel stigmatised by recognising or showing the emotions they experience and any problems they develop. Staff who experience distress that persists for more than two weeks after a significant event should receive assessments of their needs.

Recommendation 12: FPHC should encourage pre-hospital care organisations to promote knowledge of the evidence showing that employees gain psychosocial benefits from knowing that their employer has a comprehensive strategy in place to support their wellbeing, psychosocial needs and mental health and that employees who are well supported tend to make fewer mistakes

Pre-hospital care organisations should develop a strategy for supporting the wellbeing, psychosocial care, and mental health of their staff. Staff should be aware of the existence of this strategy and should have access to it. The Faculty of Pre-Hospital Care is in a strong position to promote dissemination of the knowledge and skills required to deliver effective wellbeing, psychosocial care and mental healthcare through organisations that deliver pre-hospital care services.

PART 5: RESOURCES

THE DOS AND DON'TS IN CARING FOR STAFF

This list of suggested of Dos and Don'ts in Caring for Staff are developed from a briefing paper for professional and general managers, The Top Ten Messages for Supporting Healthcare Staff During the Covid-19 Pandemic, written by Williams et al., and published by the Royal College of Psychiatrists in April 2020.[44] This advice goes beyond COVID-19 and applies to all emergencies and incidents.

Things to Do

1. **Be Kind to Yourself and One Another:** Encourage staff to be kind to themselves and then be kind to others.
2. **Assist staff to Manage their Concerns:** Enable staff to acknowledge and discuss their real concerns so that they can be supported in meeting them. Concerns might include what access there will be to psychosocial support from within their teams. Ensure every employee has a person or a place to which they can go for immediate support and ensure staff have space and time for reflection.
3. **Encourage Staff to Sustain Their Social Connections:** Encourage staff to sustain their social connections and maintain contact with families, friends and colleagues who they regard as sources of social support whether they are at work or away from work because of illness or exclusion following, for example, self-isolation requirements. Connect often and by any means and share positive news.
4. **Respond to Moral Distress and Ethical Considerations:** Effective leaders should recognise the potential impacts of the pandemic on the standards of care and that staff face moral strain and distress as they are unable, or feel unable, to do everything possible for all patients. Managers should agree a local process for developing an ethical framework for staff to work within.
5. **Remember to Eat, Drink, Rest and Sustain Contacts with Friends and Take Breaks Within the Requirements on Social Distancing:** Remember to eat, drink and to sustain contacts with friends. All staff must be encouraged to take breaks, to make sure they get enough to eat and drink, to take exercise and to make social connections that they require.
6. **Continue Supervision and Relevant Training:** At least maintain existing levels of clinical supervision and relevant training. Ensure that opportunities for informal peer support are valued and continue. More formal peer-based support should be available that enables reflection on practice e.g., through virtual Schwartz Rounds**.**
7. **Challenge Incipient Loneliness:** Challenge incipient loneliness that comes from being very busy on the frontline and remind staff that they need to keep in contact with their families and friends, using whatever means are available and appropriate. Encourage staff to keep up-to-date with academic and research developments relating to the pandemic.
8. **Support for Frontline Staff Should be Visible:** Plan and enact a good public risk communication and advisory strategy involving staff, the public and the media, which provides timely and credible information and advice. Senior general and clinical managers should be visible to staff on the frontline and seen to share the risks, as is appropriate. Provide clear messaging about the priorities of work and care for staff in each organisation.
9. **Follow Assessment and Treatment Protocols:** Encourage staff to adhere to assessment and treatment protocols and ensure staff are aware of any necessary changes from protocols that are necessary during an emergency or major incident. Staff need to be well-informed, consulted and

involved in the plans. Employers should be aware of, and endeavour to prevent staff from developing distress, plan to assist staff to mitigate the stress that they are likely to experience and have protocols in place for fast-track referrals for staff who might be developing more serious psychosocial problems and mental disorders.

10. **Be Aware of authoritative advice and guidance as it emerges:** Be aware of the contents of the current guidance from authoritative sources including the WHO and the UK authorities.

Things Not to Do

1. A common but erroneous assumption is that everybody involved needs counselling or psychiatric treatment in the immediate aftermath of a major or untoward incident or an emergency.
2. Avoid routine screening because there is little evidence that it conveys benefit inside organisations.
3. Single-session stress debriefing and brief interventions that ask people to re-experience the events that they have survived should be avoided. NICE states that psychologically focused debriefing should not be offered for preventing or treating PTSD.
4. Force people to share their stories with you, especially very personal details.
5. Give simple reassurance like ‘everything will be OK’ or ‘at least you survived’.
6. Tell people what you think they should be feeling, thinking or how they should have acted earlier.
7. Tell people why you think they have suffered by alluding to personal behaviours or beliefs of people affected.
8. Make promises that may not be kept.
9. Criticise existing services or rescue activities in front of people in need of those services.

PSYCHOLOGICAL FIRST AID (PFA) FOR PRE-HOSPITAL PRACTITIONERS

At and after an emergency, you are likely to be working with people who are upset, fearful, worried, and possibly confused, at least in the initial stages. They may be apprehensive about the future and their recovery, sleep poorly and/or have nightmares. They may be anxious and have a loss of confidence in themselves and others. Later, they may be bereaved and grieving and especially so if someone close to them is injured or killed.

Your goal in providing responses based on the principles of psychological first aid (PFA) is to promote an environment of safety, calm, connectedness, self-efficacy, empowerment, hope, healing, and confidence in their professional carers. Remember also that their relatives and close friends may be having very similar experiences and may also need support.

What You Can Do to Help Yourself and Others

Promote Safety

- Help people get their basic needs for food and shelter met and obtain emergency medical attention
- Provide repeated, simple, and accurate information on how to meet these basic needs
- Protect them from further harm
- Provide realistic and compassionate understanding
- Remember that the term ‘safety’ applies to risk of further physical injury and also to providing an emotional environment in which people feel safe.

Promote Calm

- Offer accurate information about the emergency and the work that is underway to help people understand their situation
- Be friendly and compassionate even if people are being difficult
- Listen to people who wish to share their stories and emotions and remember that there is no right or wrong way to feel.

Promote Connectedness

- Help people to contact family and friends
- Keep families together whenever possible
- Keep children with parents and other close relatives whenever possible.

Promote Self-Efficacy

- Give practical suggestions that steer people toward helping themselves
- Engage people in meeting their own needs.

Promote Help

- Find out about appropriate services and support that are available and direct people to those services that are available

- When people express fear or worry, remind them (if you know) that more help and services are on the way.

RECOGNISING AND MANAGING STRESS

When you are exposed to traumatic events, be aware how these events can affect you personally. Most people show signs of stress after such events. When these experiences are upsetting, they may be called distress.

Over time, as you are able to resume your usual routines, these experiences should decrease.

After a stressful event, monitor your own physical and mental health. Know the signs of stress in yourself, your colleagues and your family and friends and how to get help.

Know the signs of stress

You may

- Find your energy and activity levels may increase or decrease
- Feel tempted to increase your use of tobacco, alcohol or other substances
- Experience irritability, with outbursts of anger and frequent arguing
- Have trouble relaxing or sleeping, recurring dreams and nightmares
- Cry frequently, worry excessively
- Want to be alone most of the time, and have relationship difficulties
- Blame other people for everything
- Have difficulty communicating or listening
- Have difficulty giving or accepting help
- Be less able to feel pleasure or have fun
- Experience decreased libido/sexual interest.

You may have

- Stomach aches or diarrhoea
- Headaches or other pains
- Loss of appetite or eat too much
- Sweating or having chills
- Tremors or muscle twitches, parathesia (e.g., numbness and tingling in extremities).

You may feel

- Anxious or fearful
- Have mood swings, feel self-doubt and/or sadness
- Guilty
- Angry
- Heroic, euphoric, or invulnerable
- Lack concern about things that usually interest you
- Overwhelmed by sadness.

You may

- Have trouble remembering things, and have reduced attention span
- Feel confused
- Have trouble thinking clearly and concentrating
- Have difficulty making decisions.

Know How to Relieve Stress

You can manage and alleviate your stress by taking time to take care of yourself.

Keep Yourself Healthy

- Eat well, drink water and avoid junk foods and comfort eating
- Avoid excessive amounts of caffeine and alcohol
- Do not use tobacco or other non-prescribed substances
- Get enough sleep and rest
- Take physical exercise.

Use Practical Ways to Relax

- Relax your body often by doing things that work for you - for example, hobbies, running, football
- Pace yourself between stressful activities and do fun things after a hard task
- Use time off to relax - eat a good meal, read, listen to music, take a bath, talk to family
- Talk about your feelings to family members and friends as often as you wish.

Pay Attention to Your Body, Feelings and Spirits

- Recognise and take notice of early warning signs of stress
- Recognise how your own past experiences affect your way of handling other events, and think how you handled past events
- Know that feeling stressed, depressed, guilty, or angry is common after an emergency event.

MANAGING INTENSE FEELINGS IN OTHER PEOPLE

When people are faced with an emergency and you first meet them, intense feelings are often present and appropriate. They are the result of fear, uncertainty, and apprehension.

While the suggestions here can be applied to people you meet in the course of your work, patients, their families, their friends, and other community members, they are also applicable to the responses you might experience with colleagues.

What You Can Do to Help

Communicate Calmly (using the SOLER technique – an acronym explained in the list below)

- **S**it squarely or stand using the L-stance (shoulder 90' to the other person's shoulder)
- **O**pen posture
- **L**ean forward
- **E**ye contact
- **R**elax.

Communicate Warmth

- Use a soft tone
- Smile
- Use open and welcoming gestures
- Allow the person you are talking with to dictate the distance between you.

Establish a Relationship

- Introduce yourself if they do not know you
- Ask the person what they would like to be called
- Do not shorten their name or use their first name without their permission
- With some cultures, it is important to always address the person as Mr or Mrs or other title, as appropriate.

Use Concrete Questions to Help the Person Focus on What You Wish to Know

- Use closed-end questions
- Explain why you are asking the question.

Come to an Agreement on Something

- Establishing a point of agreement about a neutral item may well help to solidify your relationship and gain the trust of the person with whom you are speaking and help to progress the dialogue
- Active listening skills are likely to help you find a point of agreement.

Speak to the Person with Respect

- Use words like please and thank you
- Do not make global statements about the person's character
- Do not lavish praise that is not believable
- Use positive language.

If the Person Becomes Agitated, He or She May:

Feel that Their Personal Space is Being Threatened

- Give the person more personal space
- Remember the SOLER techniques for communication.

Challenge or Question Authority

- Answer questions(s) calmly
- Repeat your statement(s) calmly.

Refuse to Follow Direction

- Do not assert control; let the other people gain control of themselves
- Remain professional
- Present your request in another way
- Give the person time to think about your request.

Lose Control and Become Verbally Agitated

- Reply calmly
- State that you may need assistance to help them

Become Threatening

- If the person becomes threatening or intimidating and does not respond to your attempts to calm down, seek immediate assistance.

ONLINE RESOURCES

All online resources listed here accessed on 31 January 2022

Mind. Blue Light Programme Research Summary 2016-18. London: Mind; 2018. At: mind.org.uk/bluelightresearch

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NHS England Psychological First Aid Training for Staff and Volunteers. 2020. www.nhsemployers.org/news/2020/06/free-psychological-first-aid-in-emergencies-training-for-frontline-staff-and-volunteers

NHS England & Improvement and Health Education England. We are the NHS: People Plan for 2020/2021 - action for us all. London; 2020. www.england.nhs.uk/ournhspeople/

Association of Chief Ambulance Officers. Supporting ambulance staff on mental health and wellbeing. Association of Chief Ambulance Officers; 2019. aace.org.uk/mentalhealthandwellbeing/

College of Paramedics. Paramedic mental health and wellbeing: Your mental health. College of Paramedics, 2020. collegeofparamedics.co.uk/COP/Member_/Paramedic_Mental_Health_and_Wellbeing.aspx

College of Paramedics. Guidance for managers on psychosocial support and mental wellbeing of ambulance personnel in a pandemic; 2020. collegeofparamedics.co.uk/COP/News/Covid-19/Guidance_for_managers_psychosocial_support_and_mental_wellbeing_of_ambulance_personnel_in_a_pandemic.aspx

The Ambulance Service Charity. Mental Health Support. TASC; 2020.

Public Health England. Prevention Concordat for Better Mental Health**.** www.gov.uk/government/publications/prevention-concordat-for-better-mental-health-consensus-statement/prevention-concordat-for-better-mental-health

National Fire Chiefs Council. MIND Mental Health in the Emergency Services www.nationalfirechiefs.org.uk/News/nfcc-supports-every-mind-matters-campaign-/236892

GLOSSARY OF TERMS

Term	Definition
Burnout	A syndrome conceptualised as resulting from chronic workplace stress that has not been successfully managed. It is characterised by three dimensions: feelings of energy depletion or exhaustion; increased mental distance from one's job or feelings of negativism or cynicism related to one's job; and, reduced professional efficacy.
Distress	People are likely to feel stressed in emergencies and incidents. Their experiences are described as distress when they are accompanied by emotions, thoughts, and physical sensations that are upsetting or which effect their relationships. Distress is not a diagnosis but may accompany a disorder. Recent research shows that common experiences that people describe as distress include feeling very upset; fear; anxiety; fear of recurrence of the event; vigilance at social gatherings and in public places; avoiding uncomfortable feelings; and social withdrawal. The main differences between distress and the symptoms of common mental health problems lies in the severity and duration of these experiences, and the trajectory of people's recovery. Until recently, the literature has tended to underestimate the number of people who take a longer time to recover from distress.
Emotional labour	Emotional labour involves the suppression of a person's own feelings. Their outward appearance produces in others a sense of being cared for in a safe place. It is a key element in ensuring compassionate care.
First responder	A person with or without specialised training who is among the first to arrive and provide aid at the scene of an incident or emergency. Most first responders are friends, family members or members of the public; usually, they render invaluable assistance.
First professional responder	A person with specialised training who is among the first to arrive and provide aid at the scene of an incident or emergency.
Major incident	A major incident is any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties as to require special arrangements to be implemented. For the NHS, this includes any event defined as an emergency under the Civil Contingencies Act 2004
Mental healthcare	Formal biomedical and psychological treatments for mental health problems and disorders that are delivered by trained mental health practitioners. Psychosocial care is often required at the same time as a platform for these specialised treatments.
Moral distress	Moral distress occurs when staff are unable to deliver the level of care they would like, owing to organisational constraints. For example, failures in leadership, and the types of injury/illness treated in pre-hospital settings, hospitals, and communities are linked to psychosocial distress in healthcare practitioners. Moral distress arises here because the aspirations of staff to deliver high-quality care are not realised owing to limitations in the quality of care that services are able or willing to support.
Moral injury	Moral injury describes the psychological consequences of bearing witness to violence and human carnage and its aftermath. It encompasses witnessing human suffering or failing to prevent outcomes that transgress deeply held beliefs, such as the rights of children to be protected by their parents, or the belief that life can and should be preserved by appropriate and timely medical interventions. It also recognises failings in leadership, where staff are not appropriately resourced whether in terms of people, space, or equipment.
Needs and responses	Needs refer to people's requirements for assistance because of their exposure to an emergency or incident. Responses refers to the ways in which societies, communities, relatives, formal services, and practitioners act to meet the needs of people and communities during and after emergencies and major incidents.
Post Traumatic Growth	Positive psychological change experienced because of a person's struggle with challenging life circumstances. This can lead to them revising and developing new psychological and philosophical beliefs. It can stimulate growth across three domains: self-perception, interpersonal relationships, and their philosophy of life.

Term	Definition
Post-traumatic stress disorder (PTSD)	PTSD can develop after a major incident or other stressful event or situation of an exceptionally threatening or catastrophic nature. It may affect up to 25% of people of any age who have experienced an event of this nature. Symptoms include: • re-experiencing (including nightmares) • avoidance • hyperarousal (including hypervigilance, anger and irritability) • negative alterations in mood and thinking • emotional numbing • dissociation • emotional dysregulation • interpersonal difficulties or problems in relationships • negative self-perception (including feeling diminished, defeated or worthless)
Primary stressors	Primary stressors are inherent in emergencies. The term describes the sources of worry, anxiety, and stress that stem directly from the events and consequential tasks that the staff of services face during their work.
Psychological safety	Psychological safety is one component of organisational and team culture. When present, people believe that others will not resent or penalise them for asking for help, information, or feedback in psychologically safe environments. It avoids blame, belittling and undermining and emphasises constructive learning that has substantial effects on staff wellbeing.
Psychosocial	This adjective describes the emotional, cognitive, and social experiences of people in the context of their environments. It describes the interactions between psychological and social processes within and between people and across groups of people.
Psychosocial care	Psychosocial care describes interventions for people who are distressed or struggling whether or not their distress is accompanied by thoughts and feelings that interfere with their day-to-day functioning or if they have symptoms of a mental health problem that do not reach a diagnosis.
Secondary stressors	Secondary stressors are circumstances, events or policies that are not inherent in events. Secondary stressors are: 1. Social factors and people's life circumstances (that include the policies, practices, and social, organisational, and financial arrangements) that exist prior to and impact people during an emergency or major incident; and/or 2. Societal and organisational responses to an incident or emergency. Often, secondary stressors are as impactful, and, in some circumstances, more stressful than the primary stressors.
Stress	Stress is a term that is used widely and often inconsistently. Sometimes it refers to a stimulus (more appropriately described as a stressor) and sometimes to people's responses. Here, stress describes a collection of common human psychological, physical, and behavioural responses to external and internal challenge. It can be positive when it motivates people but is a problem when the level of stress people experience is overwhelming and unpleasant. Then, the experiences are described as distress. Most people experience stress in emergencies and incidents because these events may undermine their positive perceptions of the environment, themselves, their sense of control and feelings of worth.
Stressor	An event, circumstance, other occurrence, attitude, response, or something else that stimulates people to experience a stress response, or which causes a state of strain or tension.
Validation	People who are affected by emergencies and incidents regard social and professional acknowledgement of their experiences as key to their recovery. This process is called validation. It emphasises the importance of ensuring that opportunities are created for other people, whose opinions are respected, to recognise and acknowledge the experiences of, for example, Blue Light staff.
Wellbeing	This term is used in this report to refer to every member of staff's needs for certain sources of support to ensure that they are able to continue to develop, enjoy the stimulation of their work, and flourish. Every member of staff, for example, requires effective leadership and to be a member of a cohesive team that is supporting and nurturing.

PART SIX: ANNEXES

ANNEX A: STRESS, DISTRESS AND MENTAL DISORDERS

This annex provides further information on stress, psychosocial resilience, the nature of distress after incidents and emergencies, meeting the needs of responders, and the nature of psychosocial interventions.

Stress

Often, the experiences that are described as causing stress are the result of the primary and/or secondary stressors, which were defined earlier in the report and are summarised here.

Primary stressors are inherent in emergencies and major incidents and arise directly from events. Given support from relatives, friends and colleagues, many people recover relatively quickly.

Secondary stressors, by contrast, are circumstances, events or policies that are not inherent in events.[8,45]. Often, they are as impactful or, in some circumstances, more stressful than the primary stressors.

Psychosocial Resilience and Adaptive Capacities

The definition of resilience used here is based on in-depth evidence that extends beyond coping to include people's and communities' capacities to adapt and transform. The term psychosocial resilience embraces this approach.[46]

Psychosocial resilience does not describe absence of risk nor is it a synonym for resistance to the impact of events, absence of short- to medium-term distress after untoward events, or not suffering more prolonged distress if secondary stressors exacerbate it. Positive mental health or absence of mental disorders does not infer psychosocial resilience. People who are apparently coping after a major disruption, should not be assumed to be unaffected psychosocially. Good psychosocial resilience describes social and personal processes concerning how people cope at the time, adapt, and recover afterwards and the transformations they make in their lives to reduce future risks and to grow psychologically.

The three generations of adaptive capacities that give rise to psychosocial resilience are summarised here:

- First-generation resilience: the personal and social processes people use to cope well with events and their immediate aftermath
- Second-generation resilience: the processes people use to adapt to their changed circumstances and recover from events
- Third-generation resilience: the processes whereby people transform their lives and circumstances in the light of lessons learned from events or lasting impacts.

These adaptive capacities have genetic, epigenetic, psychological, social, and environmental origins. There are two interacting contributions to the features that comprise psychosocial resilience – personal and collective factors.[46] Past research has focused on the personal attributes of people who appear

to cope well with the primary and secondary stressors consequent on disasters. Southwick and Charney identified the following personal factors:[47]

- Realistic optimism
- Facing fear
- Having strong guiding values
- Spirituality
- Social support
- Physical fitness
- Mental fitness
- Cognitive and emotional flexibility and the ability to improvise
- Creating meaning and purpose from events through personal growth.

Psychosocial resilience is now regarded as a systemic, dynamic, social process in which people's social identities and attachment capacities play strong parts. This is explained by people's expectations of help and their perceptions other people who can be trusted that flow from their shared social identities.

People respond to stress by mobilising their inner personal resources: these are an array of adaptive capacities. In parallel, the support provided by their families, colleagues, friends, and the other people with whom they are in contact when untoward events occur is critically important.

Thus, the sources of adaptive capacity are personal and collective. Recent literature suggests that people who have good psychosocial resilience have the following core features:

- They receive actual support and perceive themselves as supported
- They show acceptance of reality
- They have belief in themselves that is supported by strongly held values
- They are able to improvise.

People's abilities to accept and use social support, and the availability of this support, are two of the most powerful core features of good psychosocial resilience. People's social connectedness and integration and social support have substantial effects in promoting their wellbeing and recovery after emergencies, major incidents, and disasters.

ANNEX B: THE EFFECTS OF EMERGENCIES AND MAJOR INCIDENTS ON STAFF

Introduction

This annex describes the psychosocial and mental health effects of emergencies and major incidents on staff. These effects can be both direct and indirect and may result from a single event or from repeated events. Factors that may cause distress are shown as well as those that affect risk and those that influence people's responses and recovery.

Table 2: Psychosocial and mental health effects of disasters

Direct effects of incidents and emergencies on people	Primary and secondary stressors cause stress and, often, distress: 1. Immediate and short term: a. resilient/non-disordered responses, including short-term distress b. acute stress reactions 2. Medium and longer term: persisting distress often maintained by secondary stressors 3. Grief 4. Mental disorders (NB: each one is very frequently co-morbid with other disorders): • substance use disorders • adjustment disorders • post-traumatic stress disorder • depression. 5. Impacts on personality.
Direct effects of complex, sustained or repeated disasters	1. Sustained distress that impacts on functioning 2. Exacerbations of previous mental disorders of many kinds 3. Onset of first episodes of common mental disorders
Indirect effects	Emergencies, major incidents and disasters, and particularly repeated events, increase medium and longer-term psychiatric and physical morbidity because they change the secondary stressors, medium- and long-term effects on social relationships, income and resources, and the societal conditions that shape mental and physical health, through: • increased poverty • changed social and societal relations • threats to human rights • domestic and community violence.

Potential Impacts of Repeated Events on People's Psychological Wellbeing and Mental Health

Most research has studied new, single incidents, e.g., the bombings on London's public transport on 7 July 2005. Research is underway on the impacts on people of the Manchester Arena bombing in 2017. Greater awareness of the family, social group and community effects is contributing to more socially nuanced information. Therefore, as research methods improve, new evidence is likely to continue to emerge.

Recently, more attention is being directed to the impacts on people of repeated and recurrent events or of their being involved in continuing, long-lasting situations characterised by sustained concern, stress, altered lifestyles or adversity.[e.g., 48] This will be of particular concern to the FPHC and its membership.

Trajectories of People's Reactions in the Short-, Medium- and Longer-terms

This section of the report outlines four general trajectories for how people's responses to involvement in a single incident or emergency progress. Although in the days and weeks after incidents and emergencies many people, perhaps 80%, become distressed, their experience does not restrict their activities and functioning other than briefly. People affected by distressing events, including their families, return to full capability and begin recovering their lives, relationships, property, and jobs, sometimes quickly and sometimes more slowly. Often families and communities come together in the aftermath and the social support that people gain from this is vital to effective recovery.

While people involved in emergencies or incidents, either directly or indirectly and including first responders and other staff, may experience a broad spectrum of interrelated reactions, there are four recognised patterns or trajectories of response in the ensuing weeks, months, and years:

1. **Short-term distress** (around 50-60% of people) in the days and weeks after an incident or emergency. This may be accompanied by brief impairment of functioning, but people shortly return to their usual activities.
2. **More persistent distress and slower recovery** (around 10-30%). In these circumstances, distress may be accompanied by social impairment and is often sustained or made worse by secondary stressors, e.g., health, housing, legal, work, and financial difficulties. People may increase their use of alcohol and drugs as a means of coping. They require assessment and advice.
3. **Deteriorating responses** that often mean people suffer prolonged stress (around 10%). Those in this group are at much greater risk of developing mental health problems and may require assessment by specialist mental health practitioners.
4. **High stress responses** (around 5-10%). People in this group are at much greater risk of developing mental health problems and may require assessment by specialist mental health practitioners.

Distress

Adverse situations may undermine people's positive perceptions of the environment and themselves, their sense of control and feelings of worth, leading, possibly, to their experiencing stress. On a temporary basis, people may have insufficient emotional, cognitive, social or physical resources to cope with events. Typically, people's experiences and feelings are described as distress when events challenge their tolerance and adaptation. Distress is an anticipated human condition and not a disorder when it, and any associated psychosocial dysfunction, emerges and persists in proportion to external stressful situations.

Table 1 summarises the array of experiences that people may have in the immediate aftermath of disasters. Distressed people have a mix of some of these.

More severe or more disrupting distress, or when it is associated with limitations of function, is described as an acute stress reaction. However, that term should be used with care to differentiate it from acute stress disorder and post-traumatic stress disorder (PTSD), which, if and when it occurs, more often develops in the medium- and long-terms rather than in the immediate aftermath of incidents and emergencies. Some clinicians also use the term acute stress disorder for conditions with patterns of symptoms and signs similar to PTSD, but which occur before it is legitimate (according to diagnostic categorisation schemes such as DSM 5) to diagnose PTSD.

Table 3: Indicators of distress

Emotional experiences	Cognitive experiences
Fear and anxiety	Impaired memory
Fear of recurrence	Impaired concentration
Helplessness and/or hopelessness	Confusion or disorientation
Guilt	Dissociation or denial
Anger	Intrusive thoughts
Shock and numbness[2]	Reduced confidence of self-esteem
Anhedonia	Hypervigilance
Social experiences	**Physical experiences**
Regression	Insomnia
Withdrawal	Headaches
Irritability	Somatic complaints
Interpersonal conflict	Reduced appetite
Avoidance	Reduced energy
	Hyperarousal

Greater consideration should be given to discovering whether people who are experiencing distress that lasts more than several weeks are experiencing secondary stressors that are sustaining their distress, as this form of distress can be more incapacitating or associated with persisting dysfunction. Usually, secondary stressors are tractable and can be alleviated, but some people with persisting experiences may be developing mental disorders.

Most people affected by disasters do not require access to specialist mental healthcare though they are likely to benefit from lower-level psychosocial interventions. Interventions include Psychological first aid (PFA), a conceptual vehicle for initiating psychosocial care.[39] A small proportion of people may require access to mental health services. Therefore, a proportion of people who are thought to be at particular risk require monitoring over time and, in some cases, repeated clinical assessment.

Factors that Affect Risk and Influence People's Responses and Recovery

Many factors affect the risks of affected people developing more serious problems, including mental disorders. These include secondary stressors, limitations in the availability of resources e.g., PPE and social support. Research has shown several more specific experiences or circumstances can increase the risk of people developing mental disorders.

In this context, it is important, to recognise whether incidents and emergencies:

- Are sharp, brief, and transient (so-called big bang events)
- Are repeated events that result in sustained concern and stress
- Cause circumstances that alter people's lifestyles (so-called rising tide events)
- Are continuing events of the big bang nature but persist for long periods (the 2019/20 bushfires in Australia are an example of this hybrid pattern of events).

[2] Recent evidence suggests that these experiences are not as common as once thought but are more likely to be experienced after incidents that devastate community resources and order.

Each of these broad patterns may result in people enduring sustained relational, social, and financial adversity. The severity of each event's impact on community and societal infrastructure is an important factor.

Dysfunction

Dysfunction means any impairment or abnormality, whatever the cause, of people's functioning in the social, emotional, physical and/or cognitive domains. The overall personal, social, and economic costs of psychosocial, mental health and other problems may be underestimated because of the lack of valid and reliable information about the full range of difficulties that shape the lived experience of people with problems. Horizontal epidemiology has shown that dysfunction and distress may be as important as diagnosis in understanding the impacts of people's experiences and disorders on the quality of their lives and these findings are highly relevant to improving planning of interventions to assist them.[49]

Grief

Loss is a very common experience in many incidents. At the extreme end is loss of life. It may also include loss of possessions and impacts on people's health and mobility. Financial, economic and employment losses are also common.

Usually, grief is a painful but natural process. Grieving people experience intense pain when someone who is close to them dies, but also from losing relationships and property. Grieving after deaths and injuries sustained in traumatic circumstances is particularly painful and troubling. In some instances, and particularly if people do not receive the support they need, a minority may experience less natural and more pathological patterns of grief.

Common Mental Health Disorders

People may experience the full range of mental health diagnoses summarised in this report. However, the most common are:

- substance use disorders
- adjustment disorders
- anxiety disorders
- PTSD
- depression.

Co-morbidity is common.

Mental health problems tend to co-occur, and their prevalence is higher when people are exposed to incidents or emergencies caused by violent or terrorist events; and lower after 'natural' disasters.

Only a small proportion of people who have PTSD following incidents and emergencies seek diagnosis and treatment, and, when they do, years have often passed between the onset of symptoms and their seeking treatment. [42,50].

Specific Risk Factors for Mental Disorders

People exposed to terrorist events and human-made disasters are at greater risk than those exposed to, so-called, natural disasters. In addition, women, children and adolescents, older people, people with pre-existing health conditions and those who are socially disadvantaged are at increased risk of dysfunctional distress. Listed below are the experiences that research has shown increase the risk of people affected by incidents and emergencies developing new mental disorders or further episodes of previous disorders. They:

- Perceive they have experienced high threats to their lives or the lives of significant others
- Are physically injured
- React to events with substantial and sustained anger
- Face circumstances of low controllability and predictability
- Live with the possibility that the disaster might recur
- Experience disproportionate distress or dissociation at the time
- Have experienced multiple losses of relatives, friends and colleagues to whom they were close, and losses of property that was important to them
- Have been exposed to dead bodies and grotesque scenes
- Endure higher degrees of community destruction
- Perceive they have limited social support
- Are separated from people who are important to them (e.g., parents, children, other relatives, etc)
- Are exposed to subsequent life stress
- Have been exposed to a major traumatic event previously
- Have had a mental disorder previously.

People affected by exposure to incidents also continue to be at risk of developing new mental disorders, both those precipitated by the events and unrelated to the emergency. There is clear evidence that people are more susceptible to mental disorders if they:

- Are exposed to poverty; perceive that their social support is inadequate
- Have relationship problems
- Are threatened by domestic and community violence
- Have their human rights undermined or their positions in society eroded.

These conditions frame the social factors for poor mental health, but their accumulated effects constitute a greater threat to people who are also affected by exposure to emergencies and other incidents.

PART SEVEN: REFERENCES

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